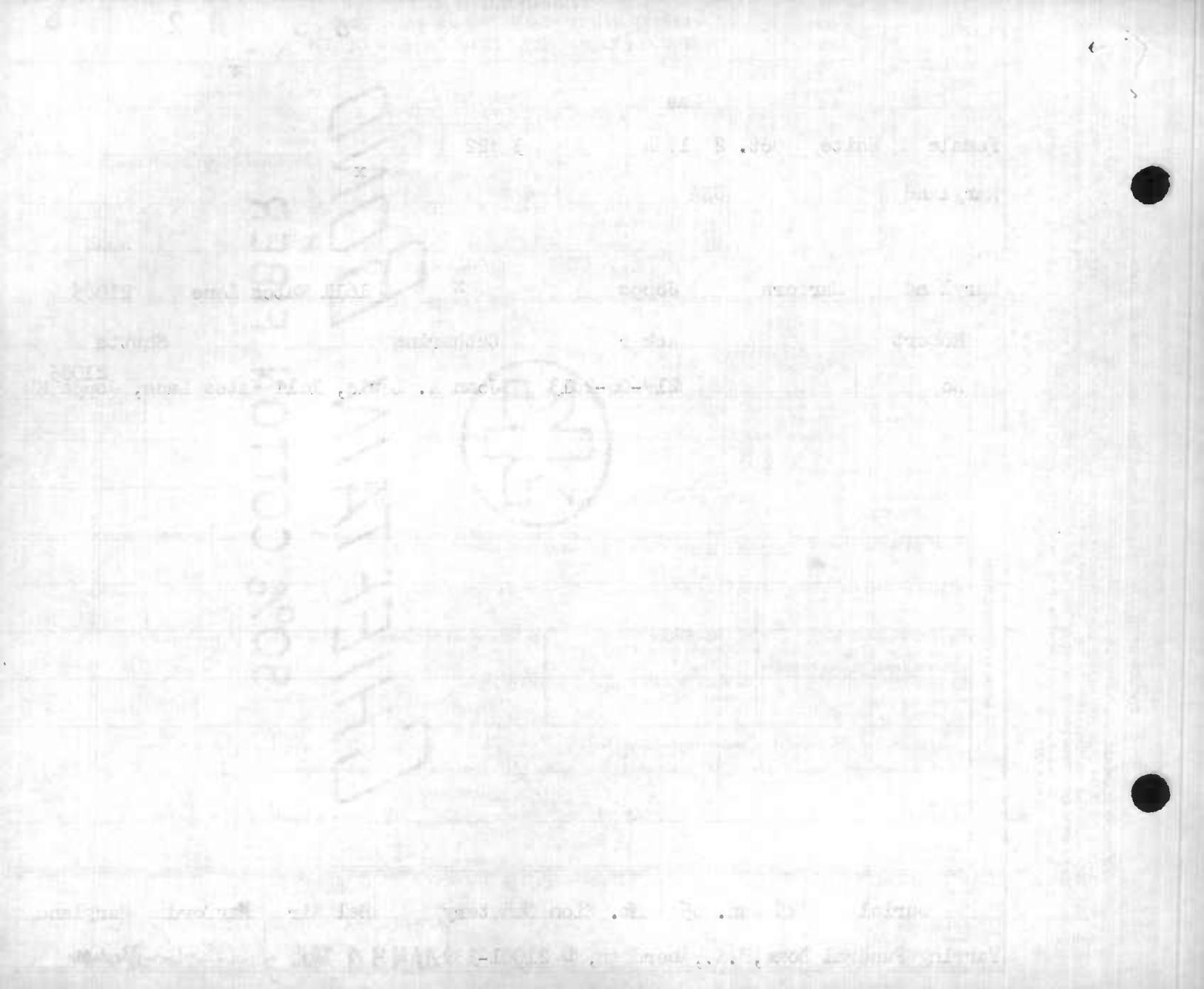


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 0 2 0 1 6		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED		2b. HOUR
Dollie Mae Acker												<input checked="" type="checkbox"/> 1-24 1985		1985
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MONTH	10. DAY	11. YEAR	12. MONTH	13. DAY	14. YEAR	15. HOUR		
Female	White	Oct. 2 1984	YRS. 3 22	MONTHS	DAYS	8:30	1-24	1985	8:30	a.m.				
16. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			17b. KIND OF BUSINESS OR INDUSTRY			
Maryland		USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford County, MD.			NONE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. STREET ADDRESS			13. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston General Hospital						1611 Kates Lane			NONE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		17. ADDRESS				
Maryland		Harfors		Joppa		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1611 Kates Lane		21085				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Robert				Acker		Catherine				Shutts				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____		20. ADDRESS				
No		219-06-2813		Joan A. Lewis, 1611 Kates Lane, Joppa MD		Sudden Infant Death Syndrome				21085				
(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____		(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?										
				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion										
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER										
23a. EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201								
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. DATE		23d. NAME OF CEMETERY OR CREMATORIAL		23e. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		28 Jan. 85		Mt. Zion Cemetery		Bel Air		Harford		Maryland				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Tarring Funeral Home, P.A., Aberdeen, MD 21001-3399				JAN 31 1985		Julia Davidson-Pender								
BP														
DHMH - 17														
(VR A15 ME (5))														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	0	2017			
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CATHERINE Worthington									Ambrose			1/20/85				120 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			White			MONTH DAY YEAR			85			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Baltimore, Maryland			U.S.A.			FEB. 21, 1899			Harford County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Bel Air (21014)			Bel Air Nursing & Convalescent Center			Housewife			Homemaker			21014						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland			Harford Co.			Bel Air			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			404 Giles Street						
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST						
Harry						Miller			Elizabeth			Talbert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (S) 836-9372 Mr. William B. Ambrose			ADDRESS 332 Giles Street Bel Air, Maryland 21014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH # 2 Days						
No			220-12-4608															
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA of the Head of Pancrease</u> , 6mo.																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 1/14/85, 19, to 1/20, 19, 85, that (I) (we) last saw the deceased alive on 1/18, 19, 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1/20/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
Dudley Phillips																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Black Rock Cemetery			23d. LOCATION CITY OR TOWN Butler, Baltimore Co., Maryland			23e. COUNTY STATE						
Burial			January 23, 1985															
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS So. W. Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Julia Davidson Phillips									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502018		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
CHARLES GEORGE ARNS						1 16 85			3:35 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
MALE		White		March 15, 1920			64 65 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.					
NEW JERSEY		U.S.A.										
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN HOSP.		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Traffic Coordinator			12b. KIND OF BUSINESS OR INDUSTRY Oil					
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN FALLSTON (21047)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 2703 LAWSON Road 21047	
14. FATHER'S NAME Karl		FIRST MIDDLE LAST Arns		15. MOTHER'S MAIDEN NAME Barbara							16. LAST Engel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. - 156-05-7892		17. INFORMANT (WIFE) 877-2892 Mrs. HELEN K. ARNS			18. ADDRESS 2703 LAWSON Road FALLSTON, Maryland 21047				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPGENIC STICK												
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION												
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE LEUKEMIA												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a DIABETES												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 1/14, 19 85, to 1/16, 19 85, that (1) (we) last saw the deceased live on 1/16, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.												
22b. SIGNATURE R. Miller		22c. DEGREE MD			22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 1/16/85				
22f. PHYSICIAN'S NAME (TYPE OR PRINT)												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE January 19, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014				
24. FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR JAN 21 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendleton							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502019
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH			3. DATE OF BIRTH			4. HOUR	
Calvin George Baumgart			JANUARY 29 1985			Aug. 20, 1929			11 20	
1. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Abingdon, Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber			12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. STATE Maryland			13b. COUNTY Harford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3817 Washington Avenue 21009	
14. FATHER'S NAME FIRST George			15. MOTHER'S MAIDEN NAME FIRST Calvin Baumgart Mary Babka			16. SOCIAL SECURITY NO. Korea 213-26-8155			17. INFORMANT Mrs. Martha Baumgart, 3817 Washington Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for item (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) ATHEROSCLEROSIS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 1129 CITY OR TOWN 1129 COUNTY 1129 STATE 1129				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/29 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 1-29-85
22b. SIGNATURE Dante U. Monakil MD			22d. DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE U. MONAKIL			22f. ADDRESS Havre de Grace, Md 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 2, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cokesbury U.M. Cemetery			23d. LOCATION CITY OR TOWN Abingdon COUNTY Harford STATE Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR JAN 31 1985			25b. REGISTRAR'S SIGNATURE John K. McComas III				





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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, group 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Hem 21 is marked or Hem 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Her Smith Page 2 Friday, Dec

MEDICAL CREDENTIALING

1 - FOR  
STATE  
REGISTRATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 2 0 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JESSIE MIDDLE Evelyn LAST BELL			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 12:54		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH <u>May 27, 1908</u> MONTH DAY YEAR 05 27 08			6. AGE (IN YEARS) <u>76</u> BIRTHDAY <u>(76)</u> IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 1 HRS HOURS MIN.	
7a. BIRTHPLACE <u>IRELAND</u> COUNTRY		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD COUNTY</u> MD.				
10. CITY OR TOWN OF DEATH <u>FALLSTON (21041)</u>						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALLSTON GENERAL HOSPITAL</u>					
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>MD</u>						12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>					
13a. STATE <u>MD</u>		13b. COUNTY <u>HARFORD</u>		13c. CITY OR TOWN <u>BEL AIR (21041)</u>		13d. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>			13e. STREET ADDRESS ZIP CODE <u>715 Country Village Drive - Apt. 3A</u>		
14. FATHER'S NAME <u>JAMES</u> FIRST <u>—</u> MIDDLE <u>—</u> LAST <u>MC NEIL</u>						15. MOTHER'S MAIDEN NAME <u>Agnes</u> FIRST <u>—</u> MIDDLE <u>—</u> LAST <u>BROWN</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>						17. INFORMANT <u>(Husband)</u> ADDRESS <u>838-1368</u> <u>Mr. John BELL</u> <u>715 Country Village Drive - Apt. 3A</u> <u>BEL AIR, Maryland 21014</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>54</u> <u>12 PM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last. <u>Massive Acute Myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Unstable Angina</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Viral Syndrome Dehydration</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <u>NO</u>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET <u>Jan 7, 1985</u> CITY OR TOWN <u>Jan 10, 1985</u> COUNTY <u>Jan 10, 1985</u> STATE <u>Jan 10, 1985</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 9, 1985</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (I/we) view the body after death.						22b. SIGNATURE <u>Albert S. C. Sun, M.D.</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22c. DATE SIGNED <u>Jan. 10, 1985</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Albert S. C. Sun, M.D.</u>						22e. ADDRESS <u>1800 Harford Rd Fallston, MD 21041</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>January 11, 1985</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Crotin &amp; Ferris Crematory</u>		23d. LOCATION CITY OR TOWN <u>West Chester, Pennsylvania 19380</u>		23e. COUNTY <u>West Chester, Pennsylvania</u>		23f. STATE <u>Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Joseph William FOSTER</u> ADDRESS <u>50 W. Broadway &amp; William St</u>						25a. DATE REC'D. BY REGISTRAR <u>Jan 14, 1985</u> 25b. REGISTRAR'S SIGNATURE <u>Julia K. Johnson</u>					
Spragueville, Pa.						Twp.					

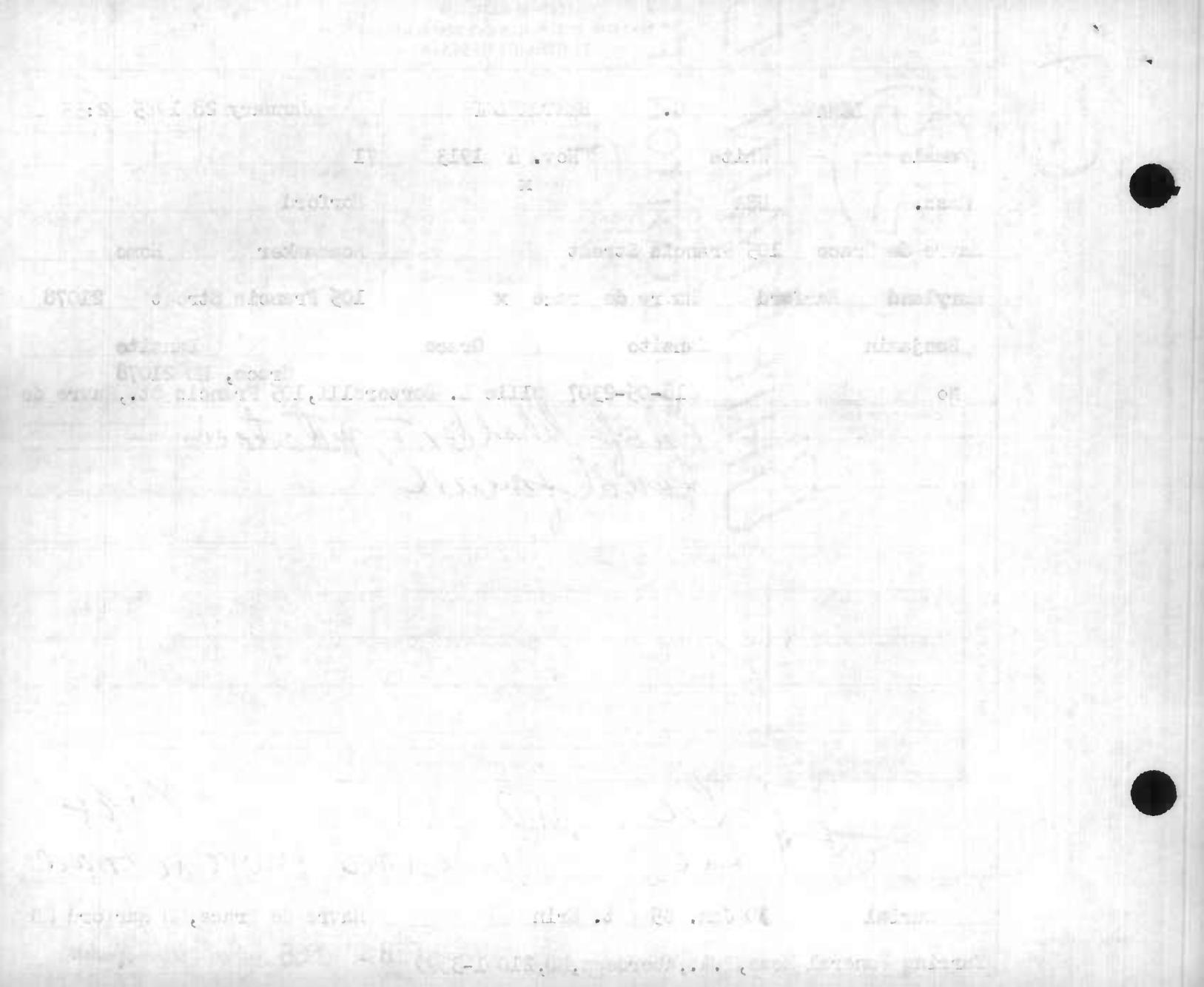


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 0 2 0 2 2										
												REG. NO.										
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			LENA			C.			BERTORELLI						January 28 1985			2:55 A M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						IF UNDER 1 YEAR			IF UNDER 24 HRS.				
Female			White			MONTH DAY YEAR			71						MONTHS DAYS			HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Mass.			USA			Nov. 4 1913									Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Havre de Grace			105 Francis Street						Homemaker			Home										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS										
Maryland			Harford			Havre de Grace			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			105 Francis Street			21078							
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE			LAST				
Benjamin						Tanzito			Grace			Grace						Tanzito				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
No			018-05-2307			Ollie L. Bertorelli, 105 Francis St., Havre de																
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												ADDRESS										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Grace, MD 21078										
{ (b) Renal failure																						
{ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE (c)																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b. SIGNATURE										
22d. PHYSICIAN'S NAME			22e. ADDRESS			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED										
Lee			McD									Feb 1 1985										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE								
Burial			30 Jan. 85			Mt. Erin			Havre de Grace, MD			Harford		MD								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE													
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3395						FEB 1 1985			John Davidson-Burdell													
DHMH-16 50M 1/81 (VRA 15, 4)																						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the Burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502023		
1 - STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
MELVIN Grant Bosely						JANUARY 8, 1985					7:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
MALE		White		April 22, 1925			59					
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Fallston Maryland		U.S.A.					Harford County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bel Air		307 GREENWAY					REAL ESTATE BROKER		REAL ESTATE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21014	
Maryland		Harford Co.		Bel Air (21014)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		307 GREENWAY			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
		Arthur	-	BOSELY	ANNA			Caroline		Fleming		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (WIFE) 879-9488 (ADDRESS)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		218-18-6624		Mrs. C. Eileen Bosely			307 GREENWAY		Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Sarcoma												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 3</u> , 19 <u>85</u> , to <u>Jan 8</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Jan 3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>David S. Ettinger</u>		DEGREE <u>MD</u>			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/8/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID S. ETTINGER MD</u>		22e. ADDRESS <u>Johns Hopkins Oncology Center</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jan. 10, 1985</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens</u>			23d. LOCATION CITY/TOWN <u>Bel Air, Harford Co., Maryland 21014</u>				
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		50 W. Broadway & Williams St. ADDRESS <u>Bel Air, Maryland 21014</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 14 1985</u>			25b. REGISTRAR'S SIGNATURE <u>John Davidson Riddle</u>				

2000 ft. - 1000 ft. - 500 ft. - 200 ft.

1000 ft. - 2000 ft. - 3000 ft. - 4000 ft.

5000 ft. - 6000 ft. - 7000 ft.

8000 ft. - 9000 ft. - 10000 ft. - 11000 ft.

12000 ft. - 13000 ft. - 14000 ft. - 15000 ft.

16000 ft. - 17000 ft. - 18000 ft. - 19000 ft.

20000 ft. - 21000 ft. - 22000 ft. - 23000 ft.

24000 ft. - 25000 ft.

26000 ft. - 27000 ft. - 28000 ft. - 29000 ft.

30000 ft. - 31000 ft. - 32000 ft. - 33000 ft.

34000 ft. - 35000 ft. - 36000 ft. - 37000 ft.

38000 ft. - 39000 ft. - 40000 ft. - 41000 ft.

42000 ft. - 43000 ft. - 44000 ft. - 45000 ft.

46000 ft. - 47000 ft. - 48000 ft. - 49000 ft.

50000 ft. - 51000 ft. - 52000 ft. - 53000 ft.

54000 ft. - 55000 ft. - 56000 ft. - 57000 ft.

58000 ft. - 59000 ft. - 60000 ft. - 61000 ft.

62000 ft. - 63000 ft. - 64000 ft. - 65000 ft.

66000 ft. - 67000 ft. - 68000 ft. - 69000 ft.

70000 ft. - 71000 ft. - 72000 ft. - 73000 ft.

74000 ft. - 75000 ft. - 76000 ft. - 77000 ft.

78000 ft. - 79000 ft. - 80000 ft. - 81000 ft.

(A)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 2 4						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES			MIDDLE MILTON			LAST BOSLEY, JR.			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
HILTON			E			E			BOSLEY			1-24-85		10 30 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
MALE			W			MONTH 5 DAY 29 YEAR 18			66			MONTHS		DAYS				
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
MARYLAND			USA						HARFORD CO.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
FALLSTON			FALLSTON GEN. HOSPITAL			Custodian			Appliance									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21014			
MD.			HARFORD			BEL AIR						510 S. MAIN STREET						
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
James			Milton			Bosley			Bertha			Mae			Magness			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			Bel Air, Md. 21014						
No			815-22-8067			Mrs. Geraldine B. Peeples, 524 S. Main St.												
18. CAUSE OF DEATH (Enter only one cause per line for item 18. Part 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
22a. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22d. I certify that (i) this hospital attended the deceased from 1-12 19-81 to 1-24 19-81 that (ii) (we) last saw the deceased alive on 1-24 19-81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not see the body after death, check here.)																		
22e. SIGNATURE			22f. DEGREE			22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22h. STAFF PHYSICIAN <input type="checkbox"/>			22i. DATE SIGNED						
22j. PHYSICIAN'S NAME, TITLE OR PRINT			22k. ADDRESS			22l. ADDRESS			22m. LOCATION CITY OR TOWN			COUNTY		STATE				
1716 Bayard Road			D.S. NAIK MD			J. Davidson Pendell			Joppa			Harford		Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN									
Burial			Jan. 28, 1985			Mountain Christian Cem.			Joppa									
24. FUNERAL DIRECTOR Howard L. McDonald, III, Abingdon, Md.			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
Estate of E. Pendell			JAN 25 1985			J. Davidson Pendell												



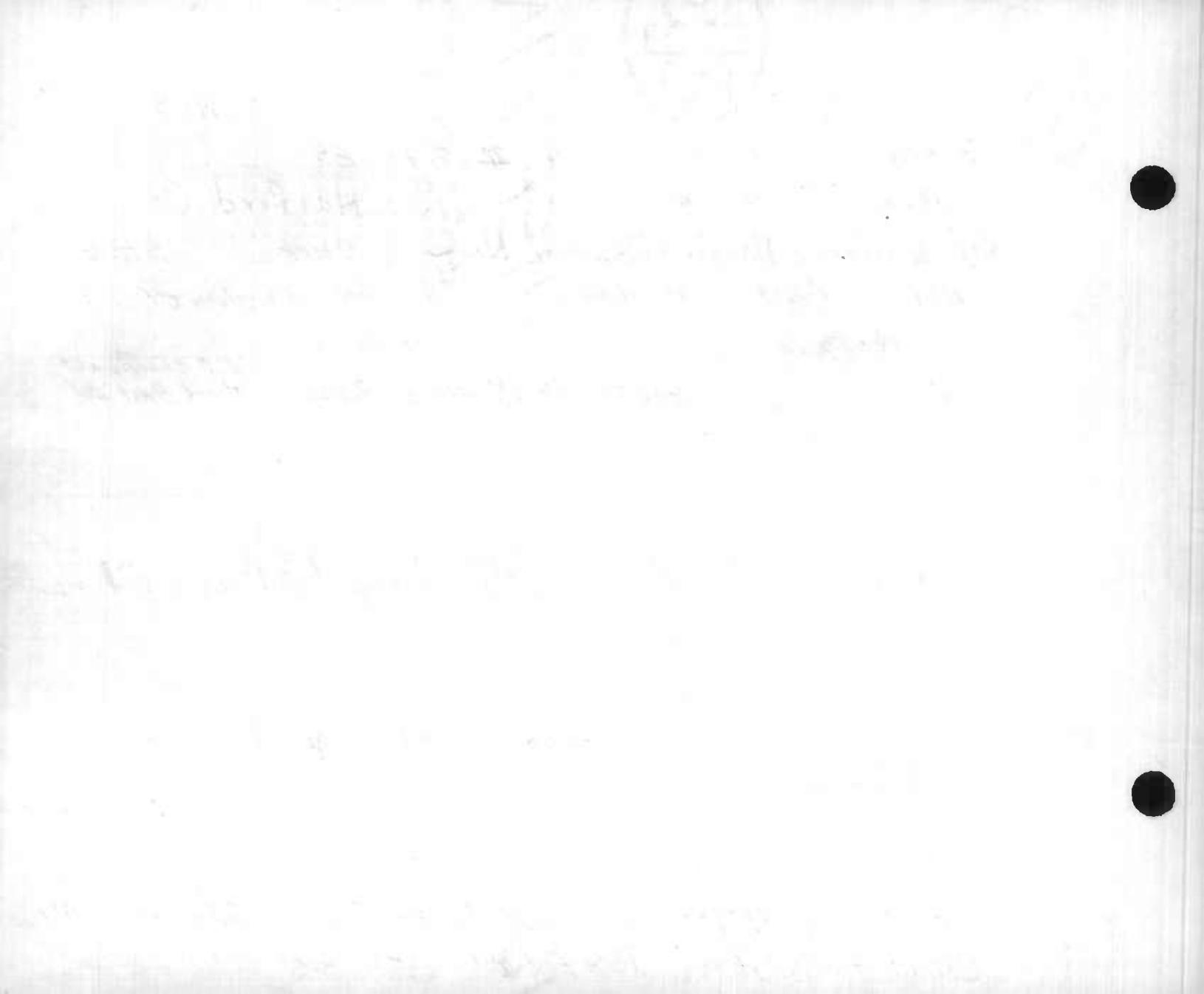
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 2 5			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Helen Elizabeth Brown						Jan 3, 1985			12 39				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Mar. 22 1919			65		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co MD.						
Penn.		U.S.A.											
10. CITY OR TOWN OF DEATH Name de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN North East			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 105 Champlain Ct			
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT 181-07-0759 Millard L. Brown			ADDRESS 105 Champlain Ct North East Md.					
18. CAUSE OF DEATH (Enter only one cause of death for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) ① Atherosclerotic heart disease ② old anticoagulant myocardial infarction													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12/30, 1984, to Jan 31, 1985, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED Jan 31, 85			
22d. SIGNATURE Mrs. W. KIM										DEGREE M.D.			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS 308 S. Union Ave Grace			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2/4/85		23c. NAME OF CEMETERY OR CREMATORIAL Delaney Valley Mem.			23d. LOCATION CITY OR TOWN No. 21078 COUNTY Baltimore STATE Md.						
24. FUNERAL DIRECTOR NAME Crouch Funeral Home		ADDRESS North East Md.			25a. DATE REC'D. BY REGISTRAR FEB 4 1985			25b. REGISTRAR'S SIGNATURE John Davidson Rendell					



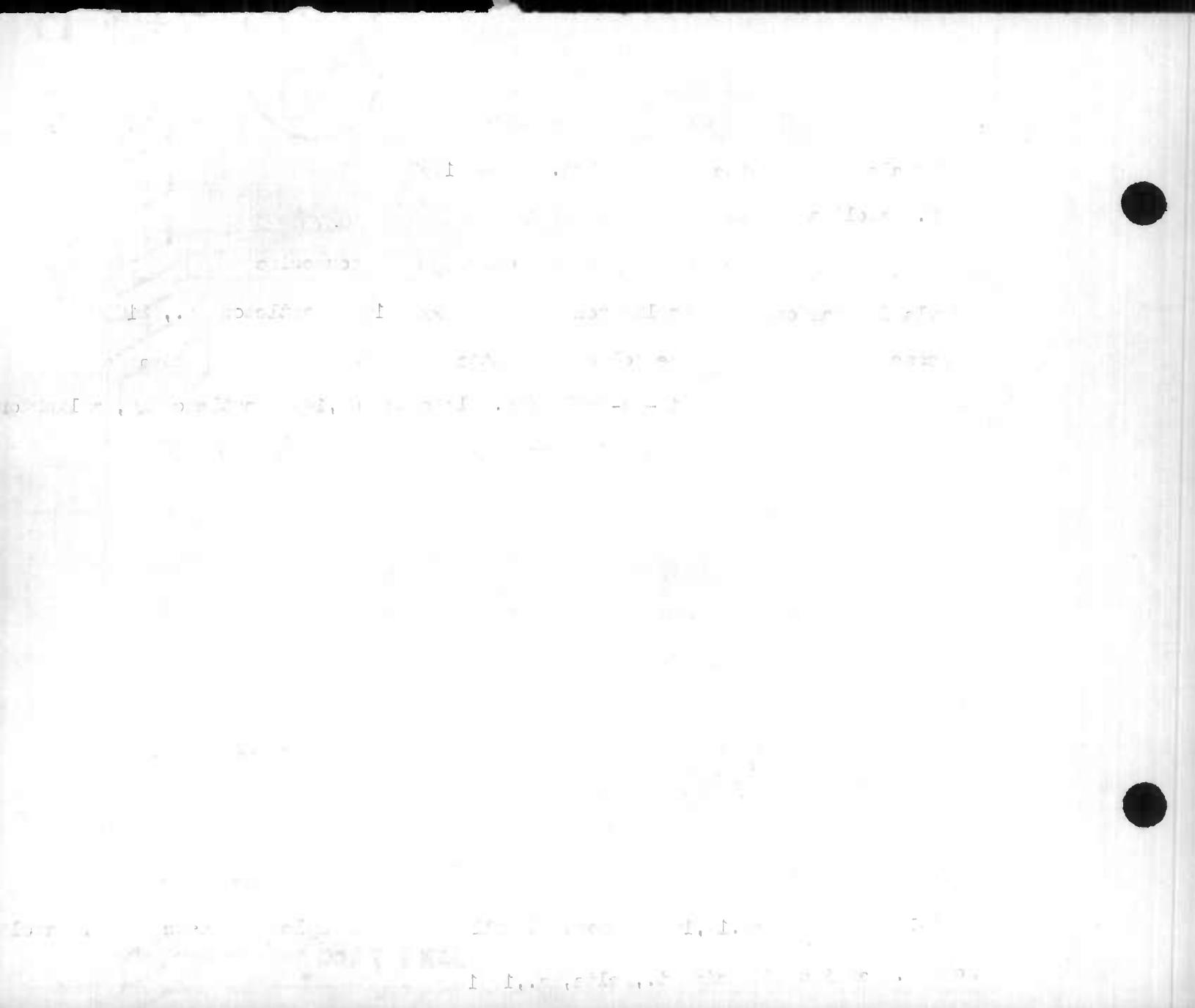
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 2 6				
1 - STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Tincie R Brown									1 14 85			2 0 1 AM		
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			Oct. 4 1897			87			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
N. Carolina			USA						Harford			YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
Harve de Grace			Harford Memorial Hospital			Housewife								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Harford			Darlington						1996 Castleton Rd., 21034		
14. FATHER'S NAME FIRST MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE			LAST					
Jesse			Reynolds			Etta			Edwards					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			213-74-7628			Mrs. Clarence Fox, 1996 Castleton Rd, Darlington								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Acute myocardial infarction														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 1/14/85 to 1/14/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE John H. Harkins										DEGREE				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Harkins			22d. ADDRESS 600 Main St., Delta, Pa., 17314			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 1/14/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 18, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Chestnut Hill			23d. LOCATION CITY OR TOWN Crumpler			COUNTY Ashe		STATE N. Carolina
24. FUNERAL DIRECTOR NAME John H. Harkins ADDRESS										DATE PREPARED FOR REGISTRATION JAN 17 1985				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 350202

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Eleanor Elizabeth Buckingham						January 24, 1985			M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
Female	White	July 9, 1912			72 YRS.						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Md.	Fallston, Md.	Fallston General Hospital			Carrier			Mail			
13a. STATE Md.						13b. COUNTY Baltimore		13c. CITY OR TOWN Sweet Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
										13e. STREET ADDRESS / ZIP CODE 4507 Carroll Manor Rd. 21013	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Holmes Perdue			Hattie Silver Wilson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS						
No	214 46 7800A	Mr. William R. Buckingham			Bel Air, Md. 21014						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS					
END-STAGE RENAL DISEASE											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.						(b)					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): IDIOPATHIC PULMONARY HEMORRHAGE											
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) N/A									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 8, 1984, to JANUARY 24, 1985, that (I) (we) lost sow the deceased alive on JANUARY 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE ROLAND C. EINHORN, MD			DEGREE			22c. DATE SIGNED 1/24/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLAND C. EINHORN, MD			22e. ADDRESS 1818 POT SPRING ROAD, STE. 102 LUTHERVILLE, MD. 21093								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/85	23c. NAME OF CEMETERY OR CREMATORIAL Chestnut Grove Presby.			23d. LOCATION CITY OR TOWN Sweet Air Road, Md.	COUNTY		STATE		
24. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC.			ADDRESS 6500 York Rd.			25a. DATE REC'D. BY REGISTRAR JAN 28 1985	25b. REGISTRAR'S SIGNATURE Devinson				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted before the certificate is signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502028		
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
ANNABELLE Louise Burlin						JANUARY 18, 1985			8:22 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS			
Female		White		Feb. 16 1926			58		YRS.			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS HOURS MIN.		
Maryland		U.S.A.					Harford					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Laure de Grace		Harford Memorial Hospital								Housewife		
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 856 Principio Road 21904		12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME William		MIDDLE ---		LAST Wyre			15. MOTHER'S MAIDEN NAME Grace		MIDDLE ---		16. LAST NAME Rocky	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-22-4767		17. INFORMANT Nathan H. Burlin			18. ADDRESS 856 Principio Road Port Deposit, Md. 21904					
18. CAUSE OF DEATH (Enter only one cause per line. See Part 1a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO, OR AS A CONSEQUENCE OF (b) <i>DOA</i>  DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John D. Yun + Neil Taylor</i>		22c. DEGREE TENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 1/18/85								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John D. Yun</i>		22f. ADDRESS <i>Laure de Grace, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE Jan. 21, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery			23d. LOCATION CITY OR TOWN Port Deposit		COUNTY Cecil	STATE Maryland		
24a. FUNERAL DIRECTOR Lee A. Patterson & Son		24b. ADDRESS Perryville, Maryland		25a. DATE REC'D. BY REGISTRAR, REGISTRAR'S SIGNATURE JAN 25 1985 <i>John D. Yun</i>								



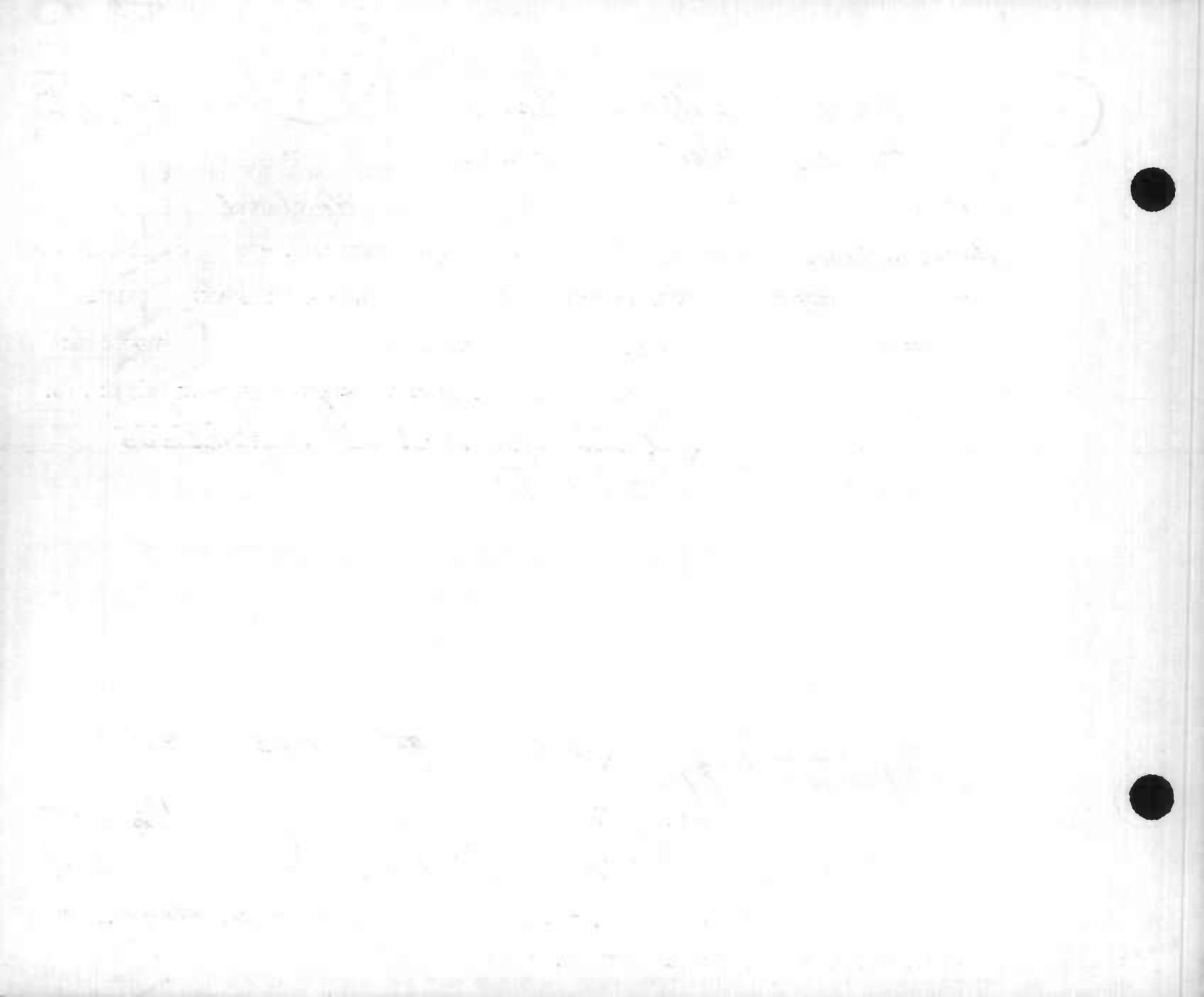
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 lists any injury, or other traumatic event, the medical examiner must be consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 2 9				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ANNA			Lillian			Cair			1-13-85		20			11 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
FEMALE		White		JANUARY 1, 1901			84		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
MARYLAND		USA					Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace		Harford Memorial Hosp		(RET) MAIN. WORK			CHEMICAL LAB (APG)							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS / ZIP CODE				
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS?			YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	310 ALLIANCE STREET 21078						
14. FATHER'S NAME FIRST GEORGE			15. MOTHER'S MAIDEN NAME FIRST KATHERINE			ADDRESS		LAST FOERTSCHBECK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219 05 1761			17. INFORMANT		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH						
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Cental Myocardial infarctus				
DUE TO, OR AS A CONSEQUENCE OF (b) BCD														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
18a. DATE OF OPERATION		18b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
22a. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22b. I certify that (i) this hospital attended the deceased from 1-3 19 85 to 1-13 19 85 that (ii) we last saw the deceased alive on 1-3 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.										22g. DATE SIGNED 1-13-85				
22h. SIGNATURE John R. Ledman		22i. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22j. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Ledman		22k. ADDRESS Havre de Grace, Md												
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 16 JANUARY 85			23c. NAME OF CEMETERY OR CREMATORIUM MT. ERIN CEMETERY			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
24 FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD.		ADDRESS 21078			25a. DATE REC'D. BY REGISTRAR JAN 16 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendell						



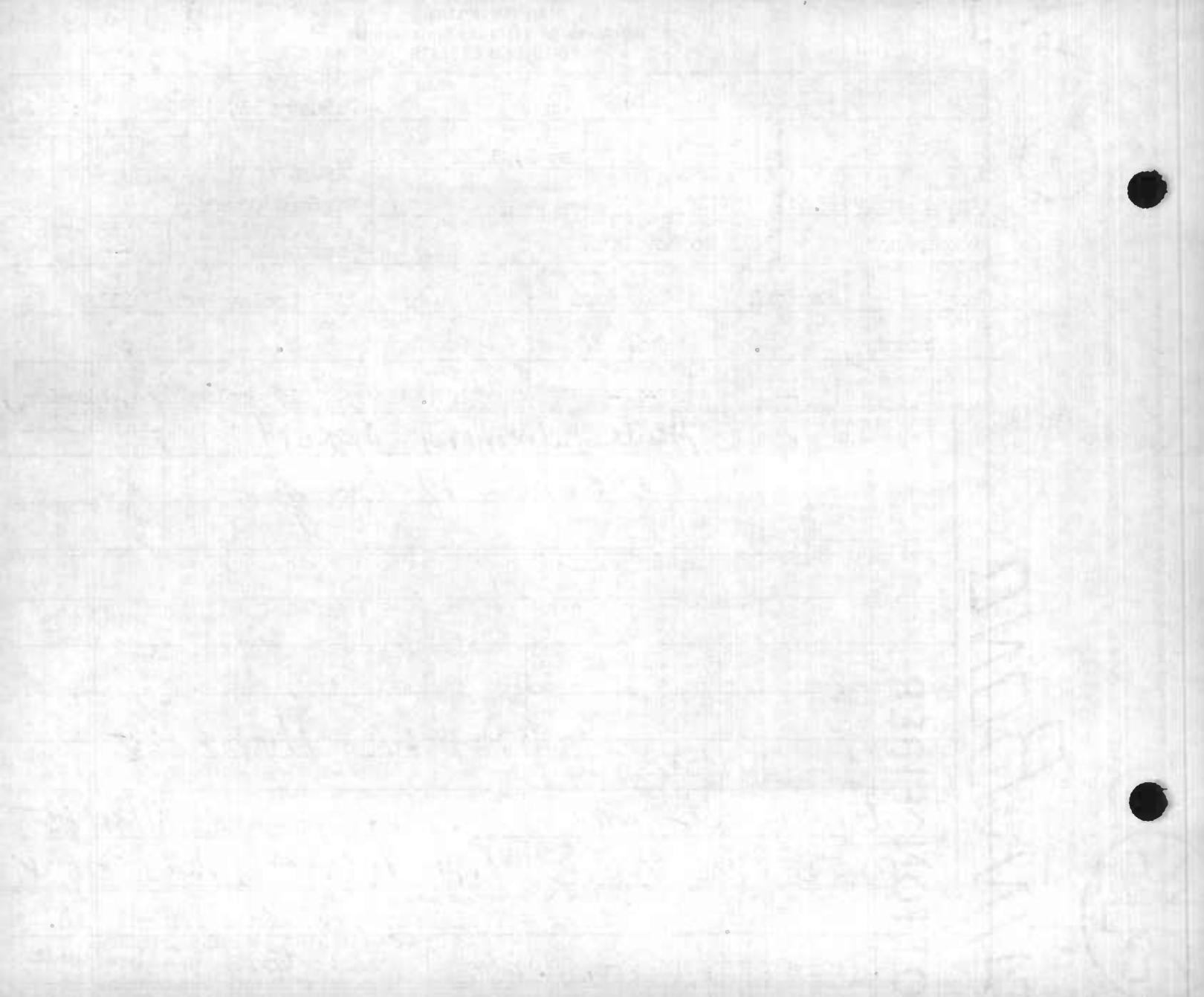
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 0 2 0 3 0								
										REG. NO.								
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
		ORIETTA			(nnn)				CAREY		January 31, 1985					5:15 A.M.		
3 SEX		4 RACE		5 DATE OF BIRTH						6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER		YEAR	IF UNDER 24 HRS			
Female		White		May 3, 1921		MONTH		DAY		63		MONTHS		YEARS	MONTHS		HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED		NEVER MARRIED		<input type="checkbox"/>		WIDOWED		DIVORCED				
Cumberland, Md.		USA				<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSIDE FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Whiteford		1619 Dooley Road										Housewife		MD.				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS										
Maryland		Harford		Whiteford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1619 Dooley Road		21160								
14 FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		FIRST MIDDLE LAST												
Joseph		M. Grim		Ada		M. Grubbs												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS												
No		212-24-0566		Joseph H. Carey, 1619 Dooley Road, Whiteford,		Md. 21160												
18 CAUSE OF DEATH: Enter only one cause per line for Part 1 and Part 2. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>Carcinoma of Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a I certify that (I) (this hospital) attended the deceased from <i>1/21/78</i> to <i>1/31/85</i> , 19, that (I) (we) lost saw the deceased alive on <i>1/21/85</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b SIGNATURE <i>Dante Monakil</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>1/31/85</i>										
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANTE MONAKIL</i>		22e ADDRESS <i>House de Grot, Md 21078</i>																
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 4, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Harford Memorial Gardens, Aldino		23d. LOCATION CITY OR TOWN Harford		COUNTY		STATE								
24 FUNERAL DIRECTOR NAME Howard K. McComas, III, Abingdon, Md. 21009		ADDRESS		25a DATE REC'D. BY REGISTRAR FEB 1 1985		25b. REGISTRAR'S SIGNATURE <i>John Dardan</i>												

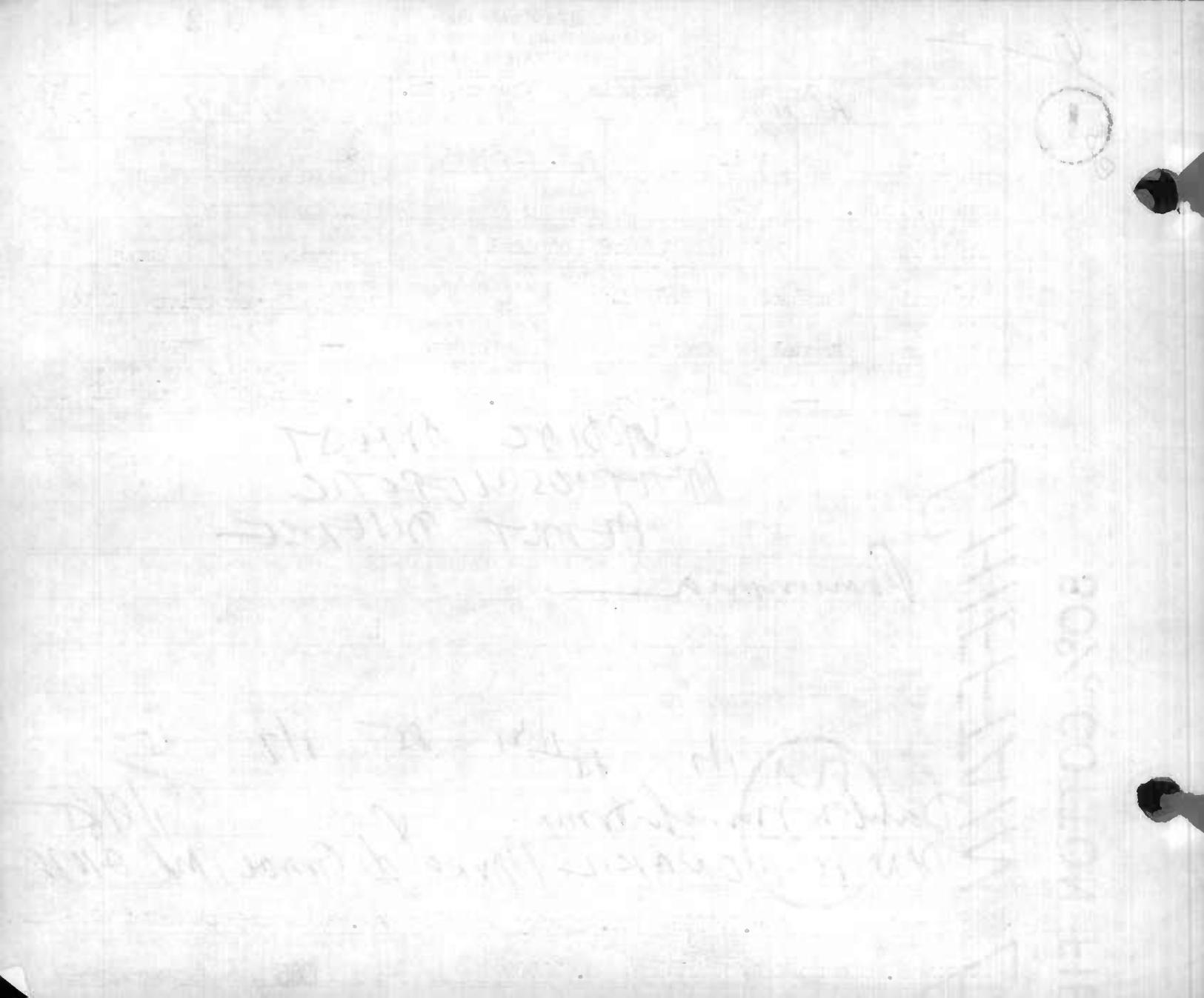


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and tamperately filled in by the funeral director, then please remove carbon papers. Please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "No", then do not bury or cremate the deceased until the medical examiner has examined the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 5 0 2 0 3										
FOR STATE REGISTRAR			REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>Arthur</u>			MIDDLE <u>Francis</u>			LAST <u>Carven, Sr.</u>			20. DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR				
												/ <u>1</u> / <u>785</u>						2 <u>30</u> P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.							
Male			White			MONTH <u>Jan.</u> DAY <u>23,</u> YEAR <u>1891</u>			93			MONTHS			DAYS							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			MD							
Boston, Mass.			USA						Harford County													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston			Fallston General Hospital									Supervisor			Candy							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS / ZIP CODE										
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			300 Sunflower Drive 21014										
14. FATHER'S NAME			FIRST <u>Owen</u>			MIDDLE <u>Samuel</u>			LAST <u>Carven</u>			15. MOTHER'S MAIDEN NAME			FIRSt <u>Honora</u>			MIDDLE <u>—</u>			LAST <u>Regan</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line.			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
No			012-90-9094			Mrs. Elizabeth M. Carven, 1357			Opiate Aluest			Bel Air			Md. 21014							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												DUE TO, OR AS A CONSEQUENCE OF (b) Opiate Aluest										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any												DUE TO, OR AS A CONSEQUENCE OF (c) Opiate Aluest										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Hemt Disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (I) (this hospital) attended deceased from the deceased alive on <u>11/11/85</u> , 19 <u>85</u> , to <u>11/17/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11/11/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED										
22c. SIGNATURE Dante Monakil			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			1/18/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dante Monakil			22e. ADDRESS Hove di Grace, Md 21078			22f. DATE REC'D. BY REGISTRAR						22g. REGISTRAR'S SIGNATURE Julia Davidson Pendall										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE Jan. 7, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Catholic Cem. Mattapan-Boston-Suffolk-Mass.			23d. LOCATION CITY OR TOWN			COUNTY			STATE							
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 8 1985			25b. REGISTRAR'S SIGNATURE													



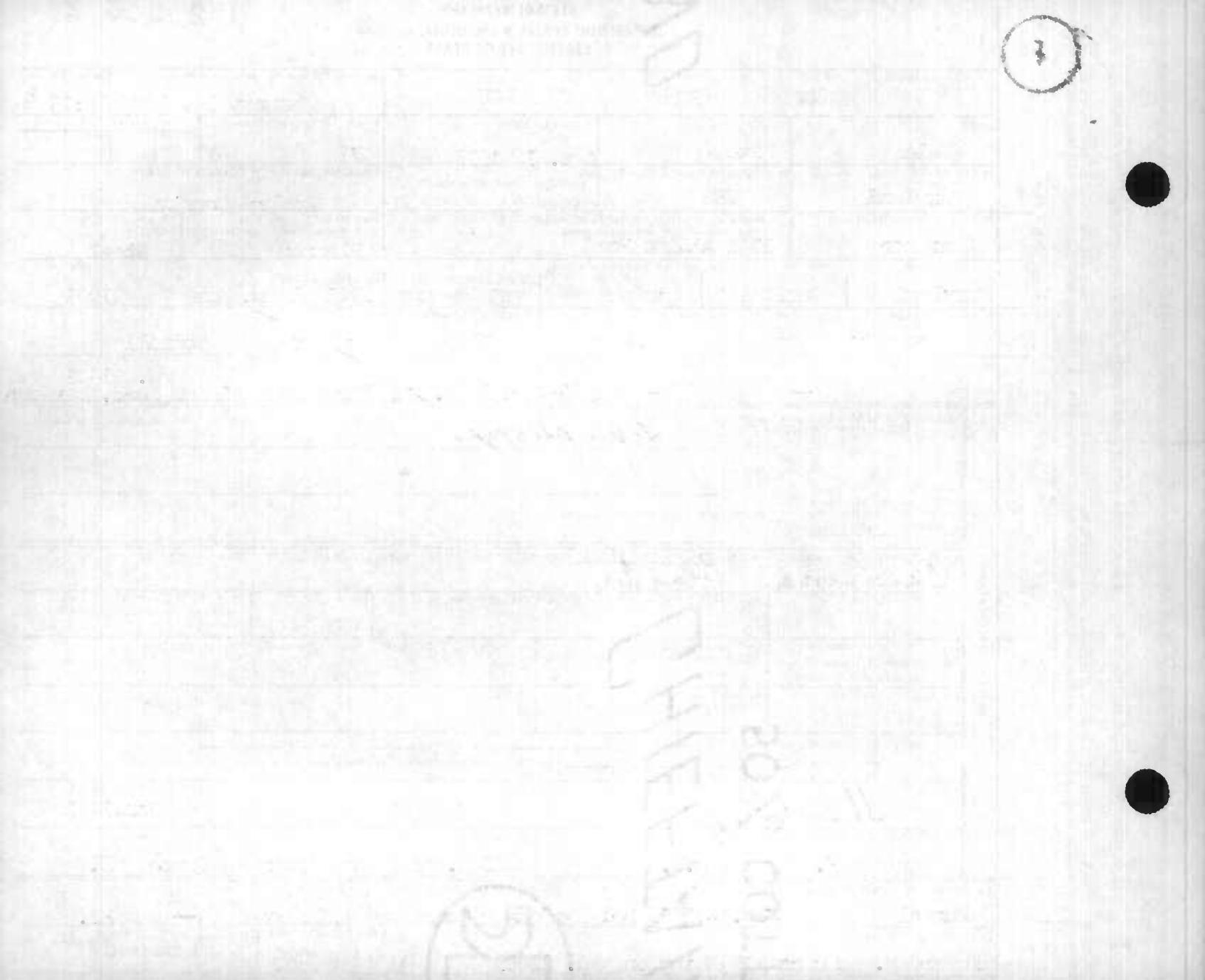
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 0 2 0 3 2					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST EDWIN	MIDDLE FENBY	LAST CHAILLOU	2a. DATE OF DEATH			MONTH January	DAY 14	YEAR 1985	2b. HOUR 10:15 A M			
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 71			IF UNDER 1 YEAR MONTHS YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			IF UNDER 24 HRS. HOURS MIN.			
10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3742 Aldino Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Planner			12b. KIND OF BUSINESS OR INDUSTRY Steel						
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3742 Aldino Road 21001			
14. FATHER'S NAME FIRST Augusto			MIDDLE Joseph			LAST Chailiou			15. MOTHER'S MAIDEN NAME FIRST Alice			MIDDLE Rebecca		LAST Connelly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. --			17. INFORMANT Edwin F. Chaillou, 3742 Aldino Road, Aberdeen			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Md. 21001						
18. CAUSE OF DEATH (Enter only one cause per line for item 18a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) _____															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____															
DUE TO, OR AS A CONSEQUENCE OF (d) _____															
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a <u>Carcinoma</u> <u>Bladder</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Leticia S. Galvez</u> DEGREE										22c. DATE SIGNED Jan. 14, 1985					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leticia S. Galvez, M.D.										22e. ADDRESS 21078 625 S. Union Ave, Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 16, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery			23d. LOCATION CITY OR TOWN Baltimore			23e. COUNTY Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009										25a. DATE REC'D. BY REGISTRAR JAN 16 1985					
										25b. REGISTRAR'S SIGNATURE <u>Davidson-Fordell</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked  there is shown any injury, or other traumatic event, the medic examiner may be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 5 0 2 0 3 3							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Mary			Elizabeth Christon			1 - 7 - 85			12 <sup>40</sup>	AM							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		Black		MONTH	DAY	YEAR	64			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
MD		USA					Hartford										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Fallston		Fallston General Hosp			Retired												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE							
										13b. COUNTY							
										13c. CITY OR TOWN							
										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
													4463 Burton Court Edgewood Md 21040				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
34195		Sarah Belle			NO				213-16-5962			Clarence Christon SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
ADRENOCORTICAL CARCINOMA																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
1b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (1) this hospital attended the deceased from 1/7/85, 19 84, to 1/7, 19 85, that (1) we last saw the deceased alive on 1/2/85, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) did not view the body after death.																	
22b. SIGNATURE K. Miller MD										DEGREE	ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/7/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE						
Burial		1-12-85		Holly Hill			Chase			Balt.	Md.						
24. FUNERAL DIRECTOR NAME Arnold Beard										25a. DATE REC'D. BY REGISTRAR JAN 7 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendell				
ADDRESS Grace, MD																	



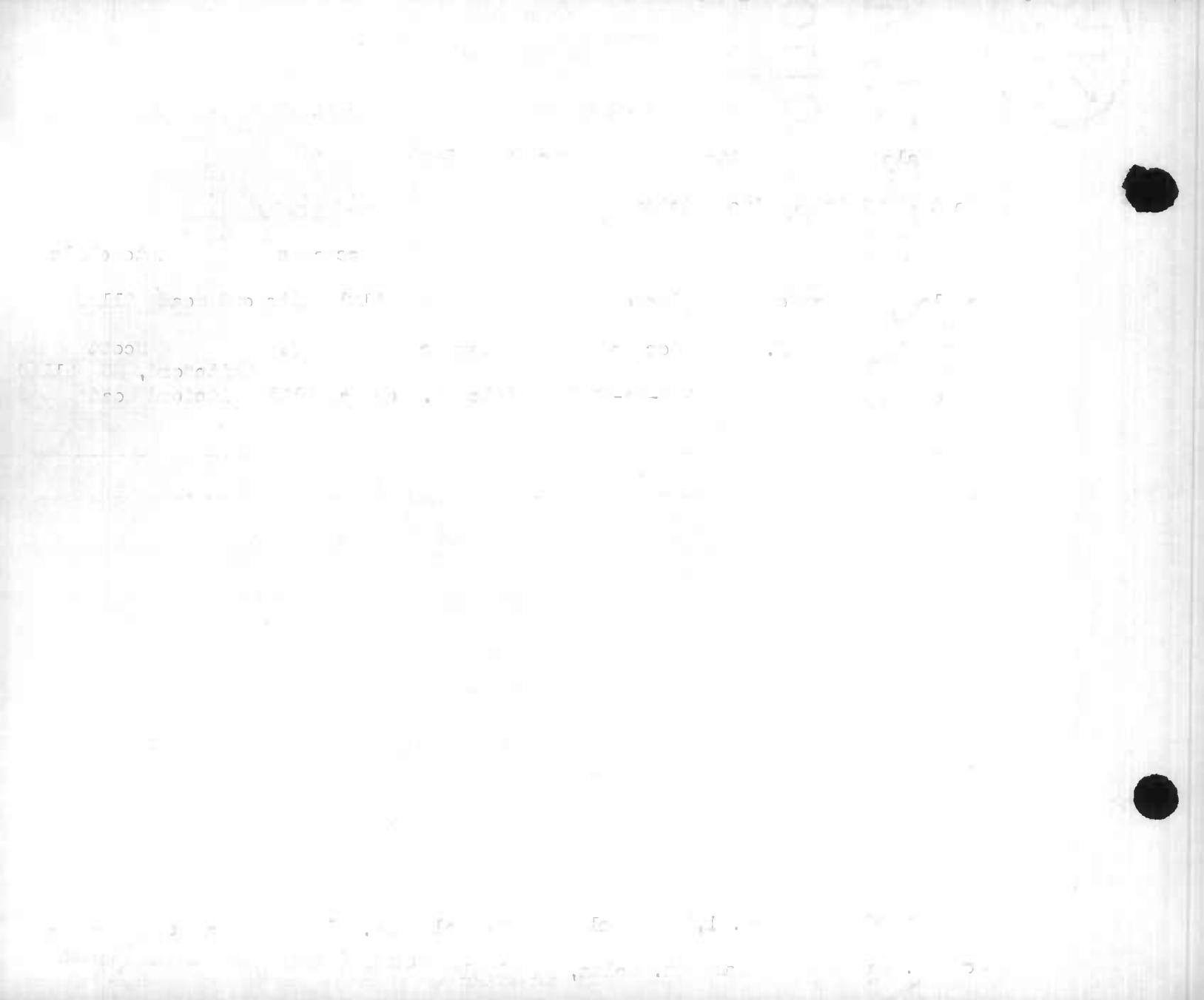
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							5 02034							
							REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Guy S. Cochran									January 30 1985				4:20 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS		
Male		White		MONTH June DAY 28 YEAR 1934			50			MONTHS YRS.		HOURS MIN.		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		United States					Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Harford de Grace		Harford Mem. Hospital		Mechanic			Automobile							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland		Harford		Whiteford			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2121 Whiteford Road 21160				
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME						
		Hubert		J.		Cochran		Carrie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		234-56-5737		Shirley M. Cochran 2121 Whiteford Road										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Cardio-respiratory Arrest</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Insufficiency</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Dis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19b.							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>1-30-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.		22b. SIGNATURE <u>Ann</u>			DEGREE			22c. DATE SIGNED <u>1-30-85</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
A. Y. Catron		611 S. Union Ave., Harford de Grace												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		Feb. 2, 1985		Bel Air Memorial Gdns., Bel Air			Harford		Maryland		Md. 21160			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
John H. Harkins		600 Main St. Delta, PA 17314			Feb 04 1985			Julia Davidson Pendell						



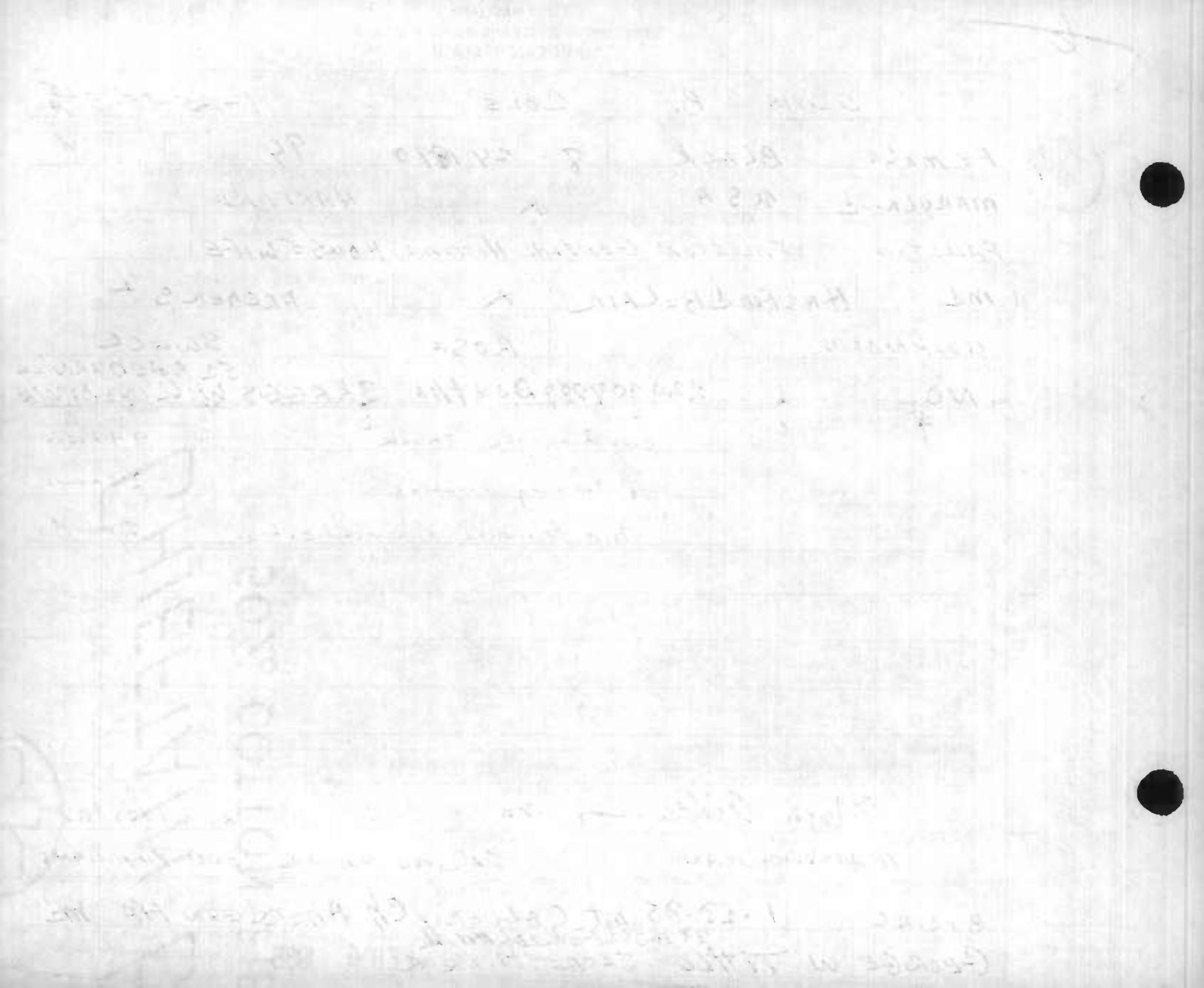
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial and memorial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be advised.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 3 5							
1 - STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR			
OLIVIA B. COLE										1-25-85				5 15 AM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			BLACK			8 24 1890			94 YRS.			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND			USA						HARFORD MD.			HOUSEWIFE 21014					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12c. STREET ADDRESS / ZIP CODE				
FALLSTON			FALLSTON GENERAL HOSPITAL										ARCHER ST.				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD			HARFORD BELAIR									52 RAEBURN LN.					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
UNKNOWN									ROSA					SWAGG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			220 304739			Dorothy SKAGGS WILLINGBOROUGH										24 hours	
DUE TO, OR AS A CONSEQUENCE OF (b)			Pulmonary embolus													24 hours	
DUE TO, OR AS A CONSEQUENCE OF (c)			hip fracture / immobilization													2 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Mark Adelman			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/25/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK ADELMAN			22e. ADDRESS FALLSTON HOSPITAL CORE PHYSICIANS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-28-85			23c. NAME OF CEMETERY OR CREMATORIAL MT CALVERE CH ABERSYGEN HA MD			23d. LOCATION CITY OR TOWN								
24. FUNERAL DIRECTOR NAME GEORGE W TITTLE			38360 Federal Hwy			ADDRESS			DATE REC'D. BY REGISTRAR FEB 4 1985			23e. REGISTRAR'S SIGNATURE Julie Davidson Pendall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 0 2 0 3 6					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
CORNELIA			F.			COLLIER			1 8 85			12:42 P M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White			MONTH DAY YEAR			90			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Tennessee			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
HARFORD			CITIZENS NURSING HOME			Homemaker											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Harford			Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			838 Old Philadelphia Rd./21001					
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST			UNK		
Houston						Hurd			Mary								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21001					
NO			212-74-5311			Ted Collier, 838 Old Phila. Rd., Aberdeen, MD											
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and for each cause)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE												STOCK CIRCULATORY COLLAPSE					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.												SEPSIS (INFECTION)					
DUE TO, OR AS A CONSEQUENCE OF (c)												PNEUMONIA					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												DEAVASATION					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on			17 19 85			19 19 85 to 18 19 85			that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
DANTE MONSARZ			DANTE MONSARZ			ADDRESS			6225 Union Ave, Havre de Grace, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			Jan. 11, 1985			Bel Air Mem. Gdns.			Bel Air, Harford, Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REC'D. BY JAN 11 1985			25b. REGISTRAR'S SIGNATURE								
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 5 7 0 2 0 3 7							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
WILLIAM ROBERT CRAIG									JANUARY 16, 1985						11:55 A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
MALE		WHITE		AUGUST 11, 1917			67			MONTHS	YEARS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
KENTUCKY		USA					HARFORD COUNTY										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
HAVRE de GRACE			706 EARLTON ROAD						(RET) EXPLOSIVES OPERATOR			FED GOVT (APC)					
USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS / ZIP CODE							
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 706 EARLTON ROAD			21078						
14. FATHER'S NAME FIRST THOMAS			MIDDLE CRAIG			15. MOTHER'S MAIDEN NAME FIRST ELLA			LAST DURMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS										
YES		WW II		311 18 7687			MRS. ELSBETH J. CRAIG			SAME AS #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Colon</u>										1 year							
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 19 83</u> to <u>Jan 16 85</u> , that (I) (we) last saw the deceased alive on <u>1-15 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Hawlett Jackson</u>										DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>1-17-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS 131 SOUTH UNION AVENUE HAVRE de GRACE, MO. 21078							
H. JACKSON, M.O.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL HARFORD MEMORIAL GARDENS			23d. LOCATION CITY OR TOWN ABERDEEN, HARFORD CO., MARYLAND		23e. COUNTY STATE								
BURIAL		19 JANUARY 85															
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078										25a. DATE REC'D. BY REGISTRAR JAN 21 1985							
										25b. REGISTRAR'S SIGNATURE <u>J. Jackson</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	5	0	2	0	3	8			
										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	Harry	MIDDLE	Elias	LAST	Crissey	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
<i>Harry</i>							<i>Crissey</i>	<i>1/21/85</i>						<i>6:14 A.M.</i>					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			White			Month Day Year July 18, 1920			64			MONTHS	YEARS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Garrett, Pa.			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Harford</i>			<i>Harford</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Fallston			<i>FALLSTON GEN</i>						Steel Worker			Steel							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
Maryland			Harford			Forest Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2925 Grier Nursery Road 21050							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST								
			William	Henry	Crissey				Edith	—	Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
Yes			WWII			175-16-9308			Mrs. Norma T. Crissey, 2925 Grier Nursery Rd.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
<i>Septicemia</i>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic atrial failure</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Septicemia</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased and saw the deceased alive on <i>1/21/85</i> , 19 <i>85</i> , to <i>1/21/85</i> , that (I) (we) last viewed the body after death.																			
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			<i>1607 Church 16 Road</i>						<i>1/21/85</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL GARDENS			23d. LOCATION										
Burial			Jan. 24, 1985			BelAir Memorial Gardens, Bel Air			CITY OR TOWN Harford			COUNTY Md.		STATE					
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III, Abingdon, Md. 21009									<i>JAN 23 1985</i>			<i>Julia Davidson-Randall</i>							



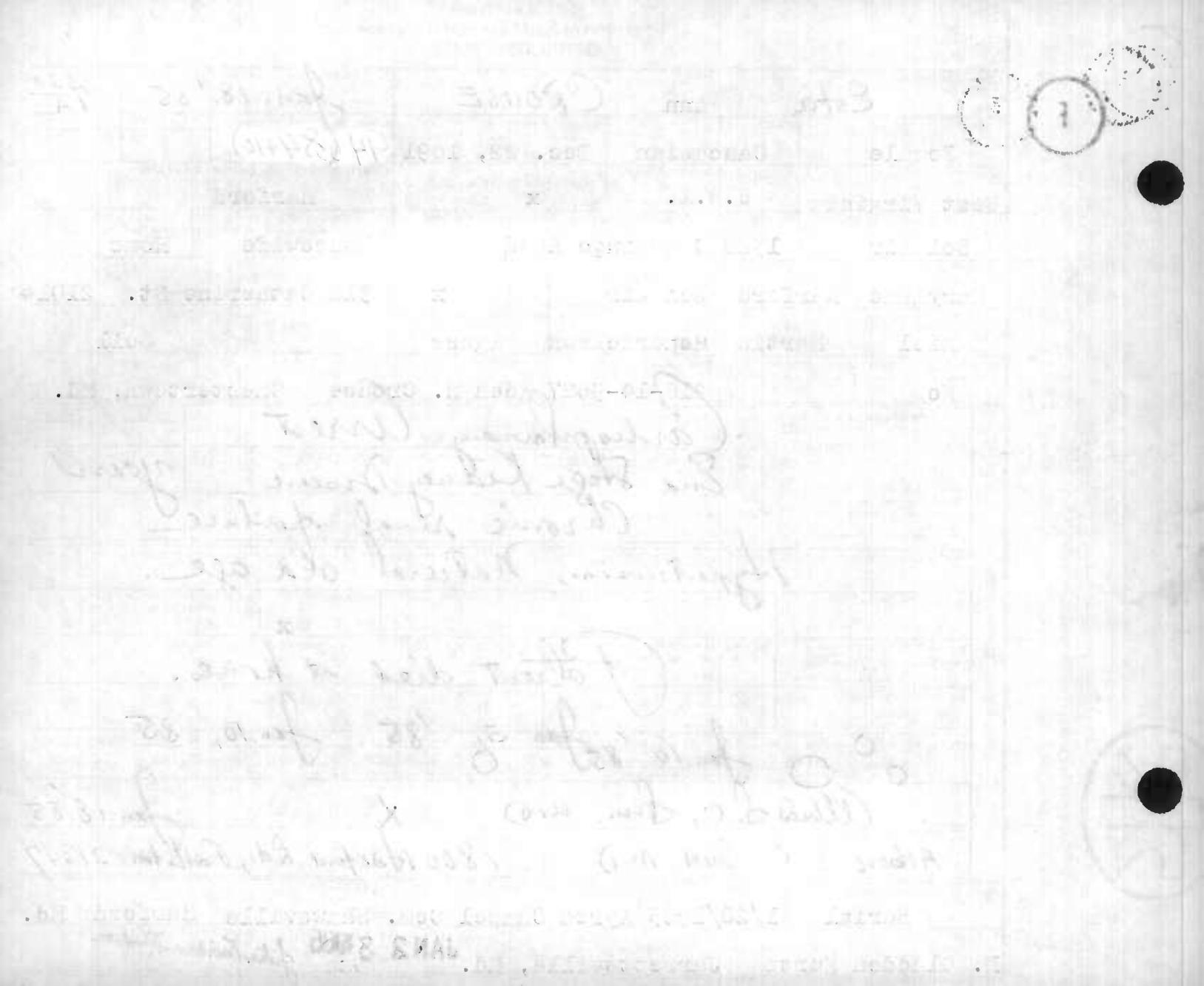
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury or other traumatic event, the medical examiner

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502039	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Estelle			Ann		Crouse	Jan. 18, '85				30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Female		Caucasian		Month Day Year Dec. 22, 1891		94 93		MONTHS DAYS		MONTHS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			11. KIND OF BUSINESS OR INDUSTRY
West Virginia		U.S.A.				Harford		Housewife			Home
12. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STREET ADDRESS / ZIP CODE		13b. KIND OF BUSINESS OR INDUSTRY			
Bel Air		1320 Conowingo Road		13b. STATE Maryland		318 Catherine St. 21014					
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Daniel		Martin	Hendrickson	Agnes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		218-14-9627		Aden H. Crouse		Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (1a)											
Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last.											
19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED NATURE OF PERSON (ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (1) (the hospital) attended the deceased from <u>Jan. 10, 1985</u> to <u>Jan. 10, 1985</u> , that (1) (we) last saw the deceased on <u>Jan. 10, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Albert S. C. Sun, M.D.											Jan. 18, 1985
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Albert S. C. Sun, M.D.				1800 Harford Rd., Fallston 21047							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		1/20/1985		Ayres Chapel Cem.		Shawsville		Harford		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
M. Gladden Kurtz		Jarrettsville, Md.		JAN 23 1985		John Davidson - Registrar					

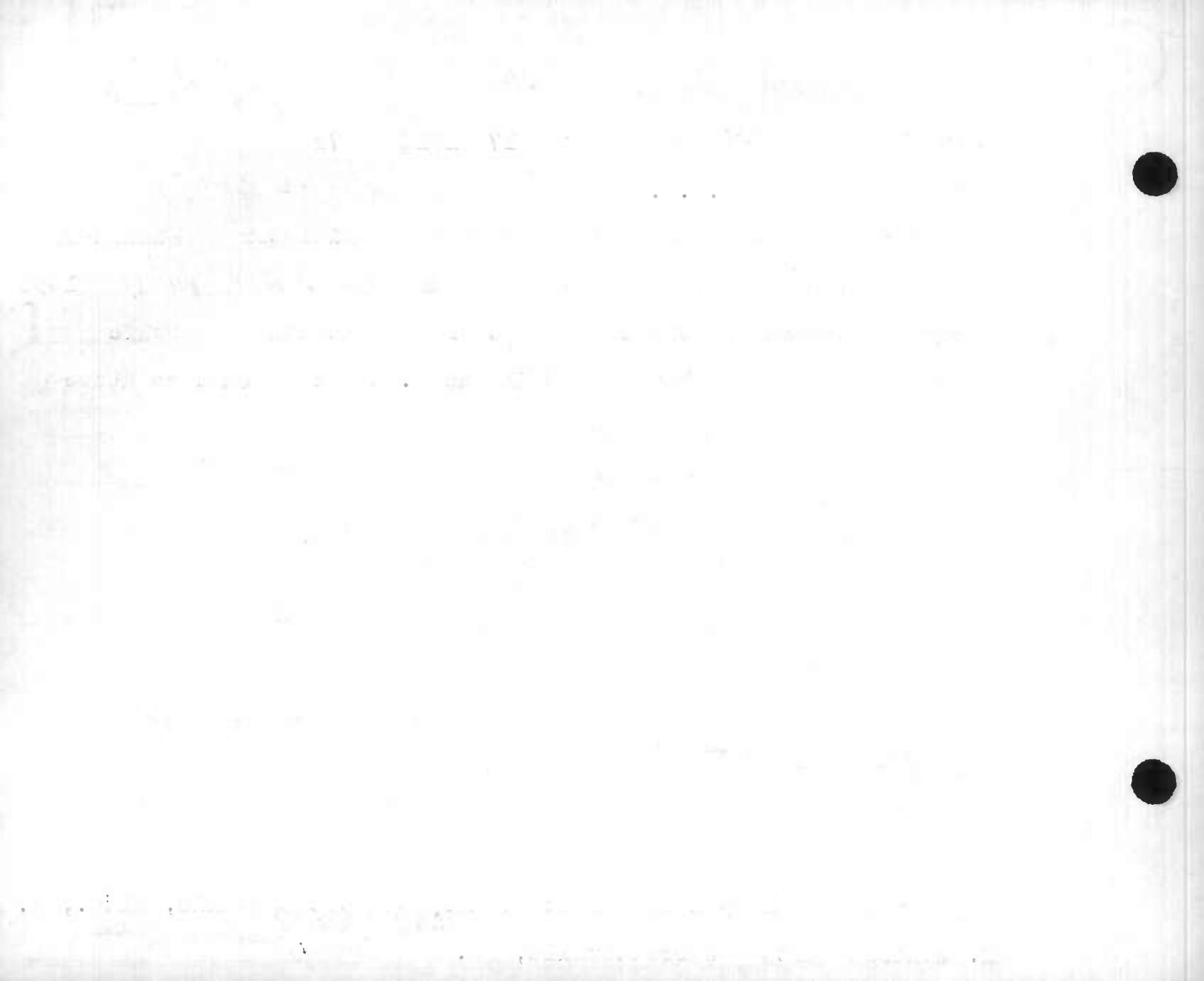


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5	02040
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
RAYMOND			Marvin	Crowe		01/21/85					110 AM		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White	MONTH	DAY	YEAR	72			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.			U.S.A.						HARFORD COUNTY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
FALLSTON			FALLSTON GENERAL HOSPITAL			Minister			Ministry				
13a. STATE MD.			13b. COUNTY HARFORD	13c. CITY OR TOWN FORST HILL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1343 BROAD ROAD	ZIP CODE		21050		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS			
Roy			Edward	Crowe	Clara			Lucretia	Wolfe	same as above			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			219-03-8081			Elaine W. Crowe							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LARGE LEFT CEREBRAL HEMISPHERE STROKE</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>EMBOLUS FROM LEFT ATRIUM</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARRITAL FIBRILLATION.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES, CORONARY ARTERY DISEASE, HYPERTENSION.</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) JAN. 12 19 85			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (s) (this hospital) attended the deceased from <u>JAN. 21 19 85</u> to <u>JAN. 21 19 85</u> , that (s) (we) lost saw the deceased alive on <u>JAN. 21 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>M. J. Sweet</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/21/85				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1/25/1985			23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Cem			23d. LOCATION CITY OR TOWN Cockscomb, Balto., Md. COUNTY STATE				
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz			ADDRESS Jarrettsville, Md.			25a. DATE REGISTERED JAN 23 1985			25b. REGISTRAR'S SIGNATURE <u>J. Gladden Kurtz</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use by the burial or cremation firm. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 4 1			
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Alice Bennett Dash						1/21/85			1:34 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Jan. 25 1913			71 YRS			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA					Harford						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston Gen Hosp.								Sales		Mercantile	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Harford		Whiteford						4328 Cooper Rd., 21160			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
		John Edward Bennett		Marie Estelle O'Connor									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No		-		215-10-3263			Patricia Dobry, 121 Othoridge Rd., 21093						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cardiac arrest.													
DUE TO, OR AS A CONSEQUENCE OF (b) D.M. ASOVD										10405.			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from Dec 1984 to Jan 20 1985, that (1) (we) last saw the deceased alive on Jan 10 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE B-D-PAREKH MD.										22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B-D-PAREKH MD.										22e. DATE SIGNED 1-21-85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1/24/85		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION CITY OR TOWN Parkville		23e. COUNTY Balto.		23f. STATE Md.		
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon, 10 W. Padonia Rd.		25a. DATE REC'D. BY REGISTRAR JAN 23 1985		25b. REGISTRAR'S SIGNATURE									
DHMH - 16 50M 4/83 (VRA 15, 4)													

33001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 4 2	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Elsa A Dehlinger						Jan 1 1985			139 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
female		Cau.		12 7 1896			88			YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Germany		U.S.A.					Harford County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bel Air (21014)		Bel Air Convalescent Center					Seamstress				
13a. STATE MD		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7707 Bagley, Balto., MD 21234				
14. FATHER'S NAME FIRST Josphph		MIDDLE LAST Schlimzer		15. MOTHER'S MAIDEN NAME FIRST Elizabeth			MIDDLE LAST Chemitzer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS				
NO		284-30-8567A		John W. Gravelle			4222 Darleigh Rd. 21236				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
BACTEREMIA										2 WEEKS	
DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION										72 YRS	
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS										>10 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Congestive Heart Failure + Pneumonia, TCS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/24/74 to 1/1/85, that (I) (we) last saw the deceased alive on JAN 1 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert J. Rosenster										DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 1/1/85											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS ROBERT J. ROSENSTER 2602 CLARET DR FALSTON MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-3-85		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland				
Entombment											
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		24a. ADDRESS 1401 BELAIR RD BALTO. MD. 21202		25a. DATE REC'D. BY REGISTRAR JAN 7 1985			25b. REGISTRAR'S SIGNATURE Julie Burden-Rosene				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 2 0 4 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR									
			Anna	Elizabeth	Dennis	1 - 28-85				300 P									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
Female		White		06	30	95	89												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH Edgewood				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 835 Mt. Vernon Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 835 Mt. Vernon Court 21040									
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST						
Casimir				Michalowski			Apolonia						Beutler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 218-03-4313			17. INFORMANT James P. Brissey Sr.			ADDRESS Same as # 13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA																			
DUE TO, OR AS A CONSEQUENCE OF (b)																			
DUE TO, OR AS A CONSEQUENCE OF (c) chy- organic Brain syndrome 2 months.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE							
22a. I certify that (i) this hospital attended the deceased from Nov. 15, 1984, to Nov. 21, 1984, that (i) (we) last saw the deceased alive on Nov. 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) did not see the body after death.																			
22b. SIGNATURE <i>B.D. Parekh</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED											
22e. PHYSICIAN'S NAME (IN DEPENDENT) B.D. Parekh, M.D.		22f. ADDRESS 1908 Harford Road, Fallston, Md. 21047																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/85		23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY	STATE								
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR FEB 1 1985			25b. REGISTRAR'S SIGNATURE <i>Davidson Pendell</i>														

20K GBP

10K GBP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	0	2	0	4	4				
												REG. NO.										
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY			MIDDLE JO			LAST DOUGHERTY			2a. DATE OF DEATH MONTH January 10, 1985			2b. HOUR 4:00 a.m.				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH April			DAY 7			YEAR 1944			6. AGE (IN YEARS LAST BIRTHDAY) 40			IF UNDER 1 YEAR MONTHS YRS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			10. CITY OR TOWN OF DEATH Pylesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 Constitution Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Pylesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 105 Constitution Road 21132										
14. FATHER'S NAME FIRST Joseph			MIDDLE L.			LAST Nealon			15. MOTHER'S MAIDEN NAME FIRST Ruth			MIDDLE LAST Knox										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-28-5661			17. INFORMANT David H. Dougherty			ADDRESS Pylesville, MD 105 Constitution Road													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic breast Ca.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any												(b)										
DUE TO, OR AS A CONSEQUENCE OF (c)																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>85</i> to <i>19</i> <i>85</i> , that (I) (we) last saw the deceased alive on <i>19</i> <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE <i>Stephen Glasser</i>												DEGREE M.D.										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED <i>1/15/85</i>																
Stephen Glasser, M.D.			600 Reisterstown Road Pikesville, MD 21208																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/14/85			23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery			23d. LOCATION CITY OR TOWN Pylesville			COUNTY Harford		STATE Maryland								
24. FUNERAL DIRECTOR NAME John H. Harkins 600 Main Street Delta, PA												25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>JAN 3 1985 John Davidson</i>										

100.

1

100. 100. 100. 100. 100. 100. 100. 100. 100. 100.

100. 100. 100. 100. 100. 100. 100. 100. 100. 100.

100. 100. 100. 100. 100. 100. 100. 100. 100. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 5 06 50 334 5								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
INGEBORG EDGAR						1/1/85			1	1	85	10 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
FEMALE		White		MONTH DAY YEAR April 19, 1921			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			GERMANY			USA			HARFORD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
FALLSTON		Fallston General Hospital			Housewife			--										
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 725 Burnside Drive 21014								
14. FATHER'S NAME FIRST George			MIDDLE --		LAST Wilksen		15. MOTHER'S MAIDEN NAME FIRST Emilie			MIDDLE --			LAST Peters					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No		16c. INFORMANT 217-28-2411			17. ADDRESS Elwood C. Edgar, 725 Burnside Drive, BelAir, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST																		
DUE TO, OR AS A CONSEQUENCE OF (b) INFERO-LATERAL M.I.																		
DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. CARDIAC ARRHYTHMIAS, HIGH BLOOD PRESSURE																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY						
22a. I certify that (I) <input type="checkbox"/> attended the deceased from approx. 1982 19 <input type="checkbox"/> to 1/1/85 19 <input type="checkbox"/> that (I) <input type="checkbox"/> last saw the deceased alive on 1/1/85 19 <input type="checkbox"/> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did <input type="checkbox"/> view the body after death.																		
22b. SIGNATURE David R. Padrino			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/1/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R. PADRINO, M.D.			22e. ADDRESS 57 E. Broadway, Bel Air, 21014															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 4, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cemetery			23d. LOCATION CITY OR TOWN Grantsville, Garrett, MD									
24. FUNERAL DIRECTOR NAME D. Lynn Newman			ADDRESS Grantsville, MD			25a. DATE REC'D. BY REGISTRAR JAN 9 1985			25b. REGISTRAR'S SIGNATURE Lela Davidson-Randall									
DHMH - 16 50M 4/82 (VRA 15, 4)																		

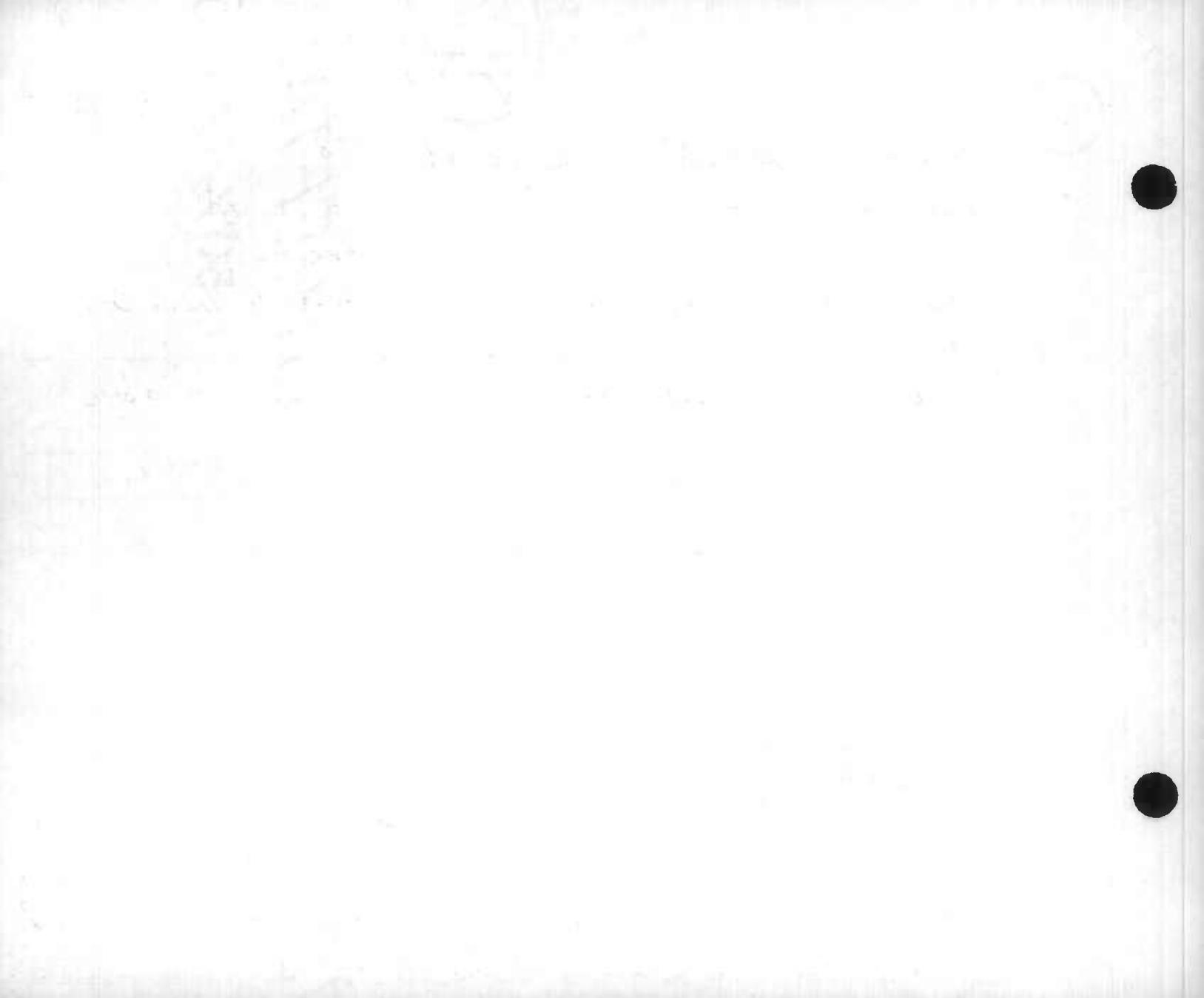
A small, circular, dark mark with a central dot, likely a hole punch or a mark from a binding.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 4 6					
1 - STATE REGISTRAR												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Menzo						Evans			Jan 19, 1985			12	10	P	12 10 P M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			Black			MONTH 2 DAY 10 YEAR 06			78			MONTHS	YEARS	MONTHS	YEARS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Georgia			USA						Harford County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace			Harford Memorial Hosp			Retired											
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			21006					
Md.			Harford Aberdeen			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2225 Williams Dr.								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Menzo			Evans Sr.														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			160-03-9880			Elsie Evans			Same as above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Cardio-pulm. arrest DUE TO, OR AS A CONSEQUENCE OF Alcohol Dehydratin + other disease																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) Alcohol + Hyp. (AD)																	
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD OMS																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																	
22b. SIGNATURE <i>John</i> DEGREE												22c. DATE SIGNED 1-26-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
A. H. CALON			611 S. UNION AVE. HDG 40														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			21008					
Burial			1-24-85			Union United			Aberdeen			Harford	County	State			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Arnold W. BEARD 353 Fountain St. Md.			HDG			JAN 25 1985			Rendell								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8502041				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR
Ethel			B.			Faber						JAN 22 1985				5:28 P.M.
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 1 HRS		
Female			white			MONTH 3 DAY 29 YEAR 98			86			MONTHS	YEARS	MONTHS	HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Harford				
Mass.			U.S.									MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Harve de Grace			Harford Memorial Hosp			Homemaker										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Md.			Harford			Bel Air			YES <input type="checkbox"/> NO <input type="checkbox"/>			61 Edendale St. P.O. Box 400 21014				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
Frank						Bonney			Mary						Harris	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
Unkn.			001-36-7598													
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Cardiac arrest																
DUE TO, OR AS A CONSEQUENCE OF (b) Active G.I. bleeding																
DUE TO, OR AS A CONSEQUENCE OF (c) Disseminating abdominal aortic aneurysm																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: A.S.C.V.D.																
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (his hospital) attended the deceased from 1-20, 1985, to 1-22, 1985, that (I) (we) last saw the deceased alive on 1-22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Charles J. Foley Jr. M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-22-85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. Foley Jr.			22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 1/23/85			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 28 1985			25b. REGISTRAR'S SIGNATURE John Davidson-Pendell							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Please forward.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502048							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Ruth			H			Flickinger			01	05	85	11:50 AM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			WHITE			MONTH DAY YEAR			78			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md			USA									Harford Co. MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston General Hospital			not employed			21050								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Md			Harford			Forest Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2264 A04 ROAD					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME											
John			Rohrbaugh			Eva						Baseman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			214747305			Family Records											
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Congestive Heart Failure, severe							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										Infected Diabetic Ulcer							
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)										Diabetes mellitus							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) <u>the hospital</u> attended the deceased from <u>12/19</u> , 19 <u>84</u> , to <u>1/5</u> , 19 <u>85</u> , that (1) <u>the</u> last saw the deceased alive on <u>1/4</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>the</u> <u>did not</u> view the body after death.																	
22b. SIGNATURE Andrew Nowakowski MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/5/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Burial			23b. DATE Jan 8, 1985			23c. NAME OF CEMETERY OR CREMATORIAL SPECIFY Mors Lano Farm PK			23d. LOCATION CITY OR TOWN Parkville, Balt. Maryland			23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Evans Chapel of Memories			ADDRESS 8800 Harford Road			25a. DATE REC'D. BY REGISTRAR Jan 10, 1985			25b. REGISTRAR'S SIGNATURE E. K. K. - K. K. - K. K.								



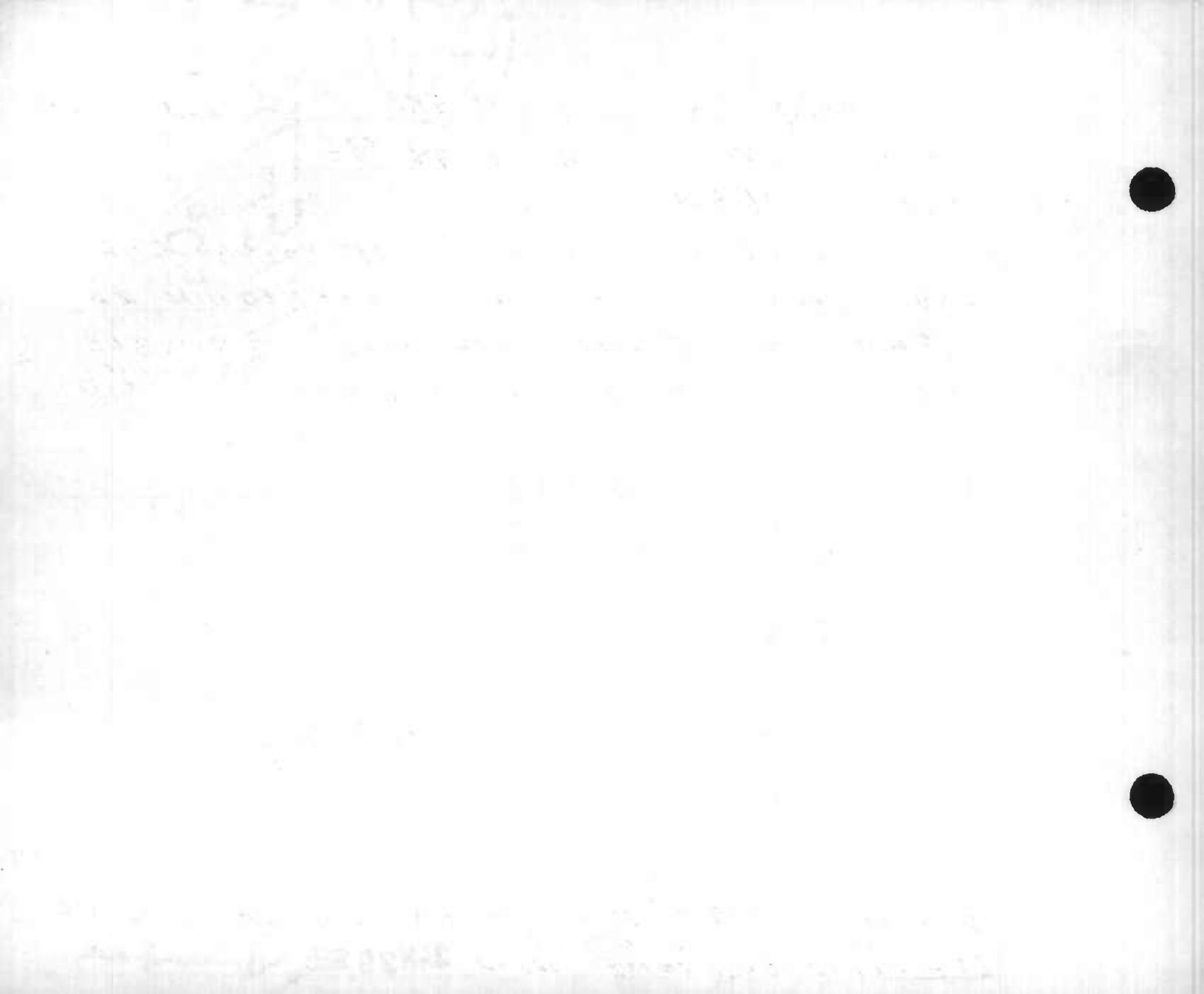
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

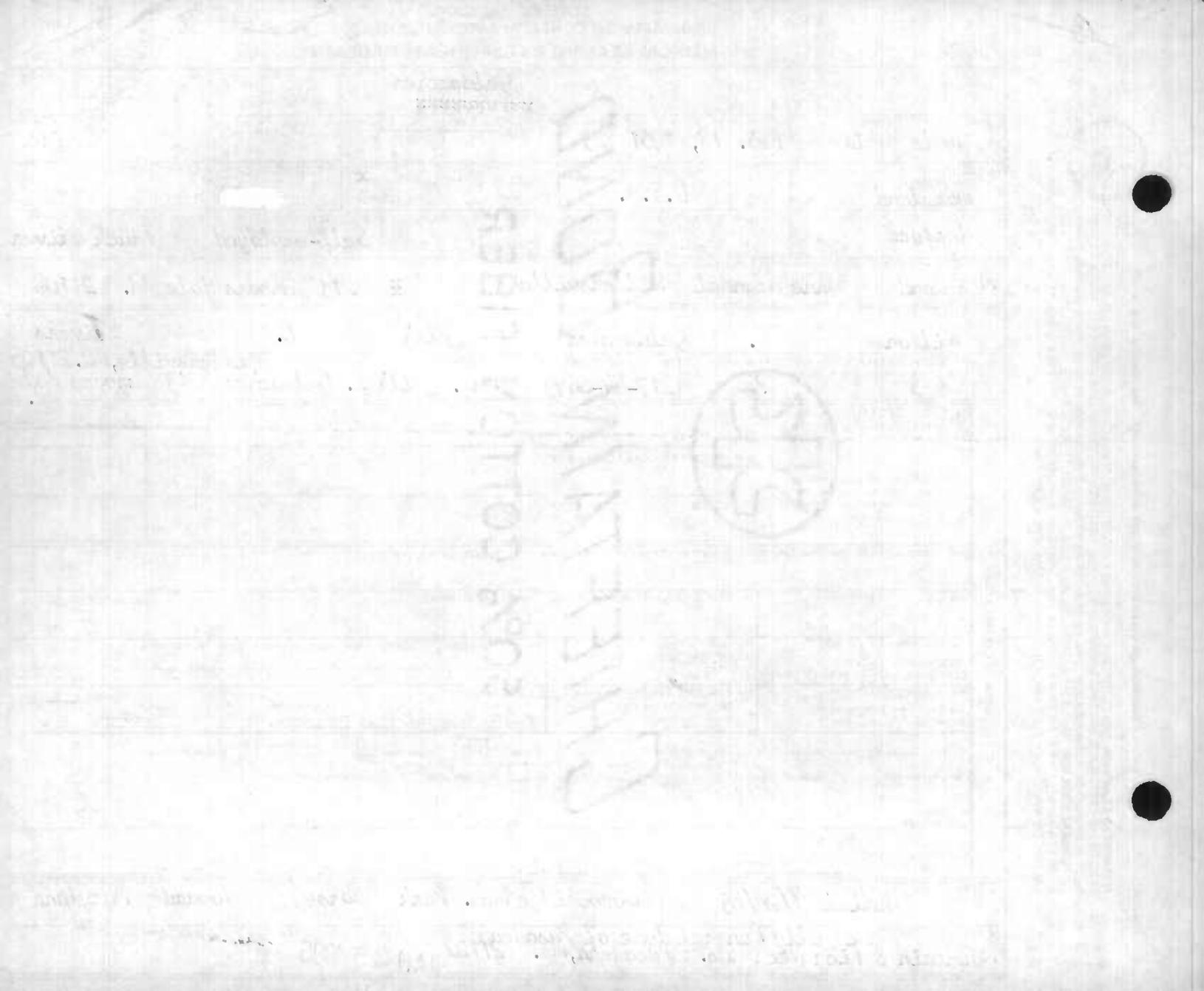
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502049						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			20. DATE OF DEATH		MONTH	DAY	YEAR	26. HOUR	
Philip A							Foster SR.			Jan. 25 1985					8:48 PM	
3. SEX		4. RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male		W			MONTH DAY YEAR		86			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD		U.S.A.						Harford								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace		Harford Memorial Hospital			RET RAILROAD			B&H			21918					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE								
MD		CECIL		CONOWINGO		YES <input checked="" type="checkbox"/>		213 CRED HILL RD								
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
JOHN F FOSTER					LULIA MAE TRIMBLE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
710		216 16 9001			PHYLIS BRECK			CONOWINGO MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post-Myocardial Infarction</u>																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>NSCOP</u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		P.M.		19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE		22c. DEGREE								22d. DATE SIGNED						
de la lour		MD								1/26/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
Rene de los Santos		2835 Churchville Rd. Churchville, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
BURIAL		1-29-85		W. NOTTINGHAM		COPORA CECIL MD										
24. FUNERAL DIRECTOR NAME		25a. ADDRESS								25b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert L. Santos		FISING 50								MAN 29 1985		Robert L. Santos				
RT FEDERAL FUTTERAL CO. INC.		ADDRESS														



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS INCURRED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PENTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

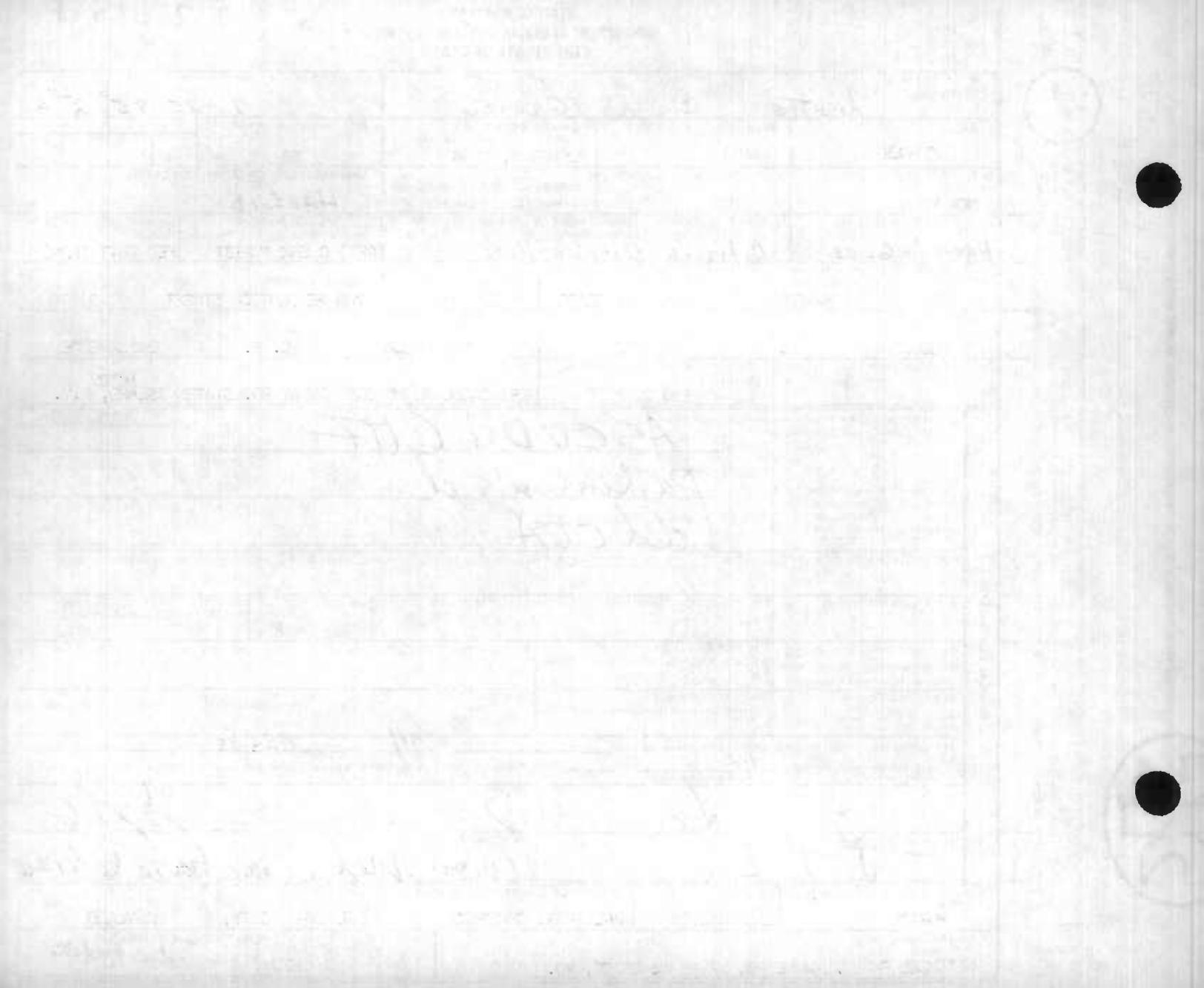


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	0	2	0	5															
												REG. NO.																				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
			LISETTE C.									GERARD			1/25/85			25	25	AM												
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			7. IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
FEMALE			WHITE			MONTH DAY YEAR			88			MONTHS DAYS			MONTHS DAYS			HOURS MIN.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
NEW YORK			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD			HARFORD			CITIZENS Nursing Home			(RET) CLERK TYPIST			FED GOVT (APG)											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
MD			HARFORD			HAVRE de GRACE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			700 REVOLUTION STREET			AUGUST H. CLARIUS			ARISTELLA			L. S.			NO			220 22 0930			MISS CAROL PLUMB 6836 AMBAY RD. STATEN ISLAND, N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for immediate and/or contributing causes)			PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			AS COAD CTF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) CONSEQUENCE OF Parkinson's d.			DUE TO (c) AS A CONSEQUENCE OF old COA																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 1-23-85 to 1977, to 1-25-85, 19, that (I) (we) last saw the deceased alive on 1-23-85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			22b. SIGNATURE J. T. Lee M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. T. Lee			22d. ADDRESS Union Med Ctr Havre de Grace			22e. DATE SIGNED 1-28-85																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BIRIAL 29 JANUARY 85			23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE CEMETERY			23d. LOCATION CITY OR TOWN BALTIMORE CITY, MARYLAND																							
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 28 1985 Lisa Davidson Pendell																										



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate

ເພື່ອມາດັ່ງນີ້ ເພື່ອມາດັ່ງນີ້

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, 203 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 32 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 55 0 2 0 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAMUEL <b>Paul</b>			LAST <b>Gibson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 24 85</b>			2b. HOUR <b>45 6 A.M.</b>	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 1, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b>			MD.	
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harfard Memorial Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) ARSENAL CHIEF			12b. KIND OF BUSINESS OR INDUSTRY FED GOVT (EDGEWOOD)			
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 701 ONTARIO STREET 21078		
14. FATHER'S NAME FIRST HUGH		MIDDLE BOYD		LAST GIBSON		15. MOTHER'S MAIDEN NAME FIRST BERTIE MIDDLE LAST WHITCOMB				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215 09 5185		17. INFORMANT MRS. MARY E. GIBSON			ADDRESS SAME AS #13e			
18. CAUSE OF DEATH (Enter only one cause per line 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO - PULMONARY FAILURE - DUE chronic</b>										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG DISEASE + ARTERIOSCLEROSIS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>PNEUMONIA</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-20</b> , 19 <b>85</b> , to <b>1-24</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-24</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <b>1/24/85</b>				
22b. SIGNATURE <b>Dante Monakil</b>		22d. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANTE MONAKIL</b>		23b. ADDRESS <b>Havre de Grace Md 21078</b>								
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23d. DATE 27 JANUARY 85		23e. NAME OF CEMETERY OR CREMATORIUM ANGEL HILL CEMETERY		23f. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MD.		23g. COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Mitchell Funeral Home PA, Havre de Grace, MD. 21078</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Lisa Davidson-Randall</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	8502053
1 - STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT)	FIRST CHARLES	MIDDLE ERNEST	LAST GLOCK	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 01 12 85 1244 AM
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 02 08	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.		
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Land Dev. & Builder	12b. KIND OF BUSINESS OR INDUSTRY Self-Employed
13a. STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 318 Reckord Rd. 21047	
14. FATHER'S NAME FIRST George	MIDDLE A.	LAST Glock	15. MOTHER'S MAIDEN NAME FIRST Katherine	MIDDLE E.	LAST Eckert
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-7711	17. INFORMANT Mrs. C. Mildred Glock, P.O. Box 10, Fallston, Md. 21047	ADDRESS 318 Reckord Rd.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>a. of Lung - Metastatic</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>bladder a &amp; distant metast</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>+ esp.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>COPD..</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (the hospital) attended the deceased from <i>1-9-8</i> , 1985, to <i>1-12</i> , 1985, that (I) (we) last saw the deceased alive on <i>1-11</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-12-1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR, M.D.	22e. ADDRESS 1716 Harford Road, Fallston, MD 21047				
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial	23b. DATE 1-15-1985	23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gar.	23d. LOCATION Belair	Harford	Md. STATE
24. FUNERAL DIRECTOR E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21088	25a. DATE REC'D. BY REGISTRAR JAN 17 1985				
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 721-722-7200.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502054			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Robert			R	Gordon				1/31/85					M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
male		white		4/21/26			58 YRS						
7a. BIRTHPLACE (COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		MD.				
10. CITY OR TOWN OF DEATH Fallston 21047		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Fallston General Hospital					12a. USUAL OCCUPATION Supervisor		12b. KIND OF BUSINESS OR Can Mfg. Co.				
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppatown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 318 Burnsider Ct. 21085				
14. FATHER'S NAME FIRST MIDDLE LAST		Russell Gordon		15. MOTHER'S MAIDEN NAME Marion Vantassell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WWII		17. INFORMANT Elizabeth Gordon, Wife			ADDRESS Same						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic obstructive pulmonary disease with respiratory failure</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>December 19 80</i> to <i>January 19 85</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>1-19 85</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.										22c. DATE SIGNED 2/1/85			
22b. SIGNATURE <i>Chi-Shiang Chen</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chi-Shiang Chen, MD		22e. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>2/4/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill Memorial Gardens		23d. LOCATION CITY OR TOWN Baltimore Co., Md.							
24. FUNERAL DIRECTOR <i>Prudzinski Funeral Home PA</i>		25a. DATE REC'D. BY REGISTRAR <i>1/20/85</i>		25b. REGISTRAR'S SIGNATURE <i>1985</i>									
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

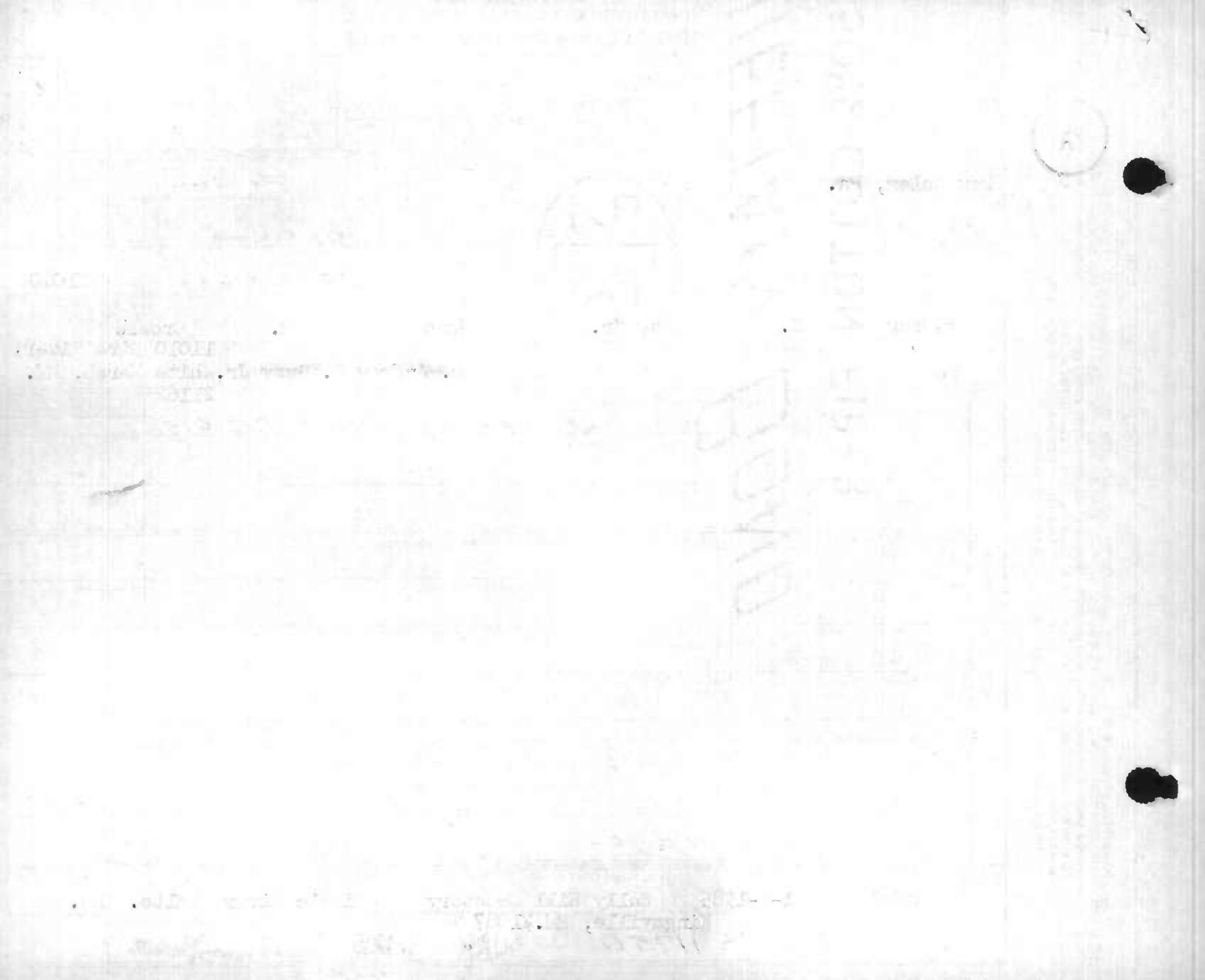
IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 02055				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
George E. Grieninger						Jan 29 1985						55 3 pm				
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
Male			white	MAY 6, 1917			67 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Harford				
NEW YORK			USA									MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace			Harford Memorial Hospital			CARPENTER			MARINA							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
Md.		Harford		Havre de Grace		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			408 STRAWBERRY LANE			21078				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST						
HARRISON			M.	GRIENINGER		BERTHA			B. E.	SEAR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			213 16 6822			MRS KATHERINE E. GRIENINGER			SAME AS #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Cerebrovascular accident, recurrent.				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriovenous Cerebrovascular disease</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>③ old cerebrovascular accident</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (ENTER IN PART 1 OR PART 2)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-10 19 85 to 1-29 19 85, that (I) (we) last saw the deceased alive on 1-29 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE			DEGREE	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED							
SANG W. KIM			308 S. Union Ave Havre de Grace, Md.									Jan. 29, 85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1FEBRUARY85			23c. NAME OF CEMETERY OR CREMATORIAL ROCK RUN CEMETERY			23d. LOCATION CITY OR TOWN ROCK RUN, HARFORD CO., MARYLAND			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR JAN 31 1985			25b. REGISTRAR'S SIGNATURE			John Harford				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED, WITHIN 24 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Terome</i> MIDDLE <i>Phillip</i> LAST <i>Guzy</i>				2a. DATE KNOWN OF DEATH MATED				MONTH <i>4</i>	DAY <i>19</i>	YEAR <i>83</i>	2b. HOUR <i>8p</i>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH <i>7</i> DAY <i>9</i> YEAR <i>38</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>46 yrs.</i>		7. IF UNDER 1 YR. MONTHS <i>0</i>		8. IF UNDER 24 HRS. DAYS <i>0</i>		9. DATE PRONOUNCED DEAD		10. DATE MONTH <i>1</i> DAY <i>4</i> YEAR <i>1983</i>		11. DATE MONTH <i>8</i> DAY <i>20</i> YEAR <i>83</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Fallston</i>					
10. CITY OR TOWN OF DEATH <i>Fallston</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General ER.</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Foreman</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>	
13a. STATE <i>Md</i>		13b. COUNTY <i>Hanover</i>		13c. CITY OR TOWN <i>Edgewater</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2032 Cherry St 21040</i>									
14. FATHER'S NAME FIRST <i>Andrew</i> MIDDLE <i>S.</i> LAST <i>Guzy Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Jane</i> MIDDLE <i>R.</i> LAST <i>Crouse</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>209-30-1395</i>				17. INFORMANT <i>Mr. Andrew S. Guzy, Jr. White Marsh, Md.</i>				ADDRESS <i>11010 Bird River Rd 21162</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. <i>19</i> MONTH <i>DAY</i> <i>YEAR</i> P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY) <i>Luis E. Reyel</i> M.D. Deputy MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>464 Alhambra St. Havre de Grace</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE <i>1-8-1985</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Holly Hill Cemetery</i>				23d. LOCATION CITY OR TOWN <i>Middle River</i> COUNTY <i>Balto. Md.</i> STATE					
24. FUNERAL DIRECTOR NAME <i>Cessah</i>				ADDRESS <i>Kingsville, Md. 21087</i>				25a. DATE REC'D. BY REGISTRAR <i>1-8-1985</i>				25b. REGISTRAR'S SIGNATURE <i>Julia Wilson Pendall</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 2 0 5 7 CERTIFICATE OF DEATH															
REG. NO.															
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST			January 22, 1985		A 9:30 M		
DOROTHY CHIVERS HARNEY															
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) London, England			7b. CITIZEN OF WHAT COUNTRY? USA			Dec. 28, 1902			82			MONTHS		DAYS	
8. YRS												HOURS		MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH Harford County														MD.	
10. CITY OR TOWN OF DEATH Abingdon			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2812 Emmorton Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SalesLady			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Abingdon			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2812 Emmorton Road 21009			
14. FATHER'S NAME FIRST Arthur			MIDDLE Bartholomew			LAST Chivers			15. MOTHER'S MAIDEN NAME Julia			LAST Andersen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --			16c. ADDRESS 217-12-8025			17. INFORMANT Mrs. Betty A. Hopkins, 2812 Emmorton Road			ADDRESS Abingdon, Md. 21009			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke (CVD)</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS C.V.D.</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1-13			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.												19 22, to 19 22, that (I) (we) last			
22b. SIGNATURE <i>Vijay S. Nair, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 1-22-85		
22e. PHYSICIAN'S NAME Vijay S. Nair, M.D.			22f. ADDRESS 1716 Harford Road, Fallston, Md. 21047												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 26, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR JAN 23 1985			25b. REGISTRAR'S SIGNATURE <i>John R. Nodell</i>									

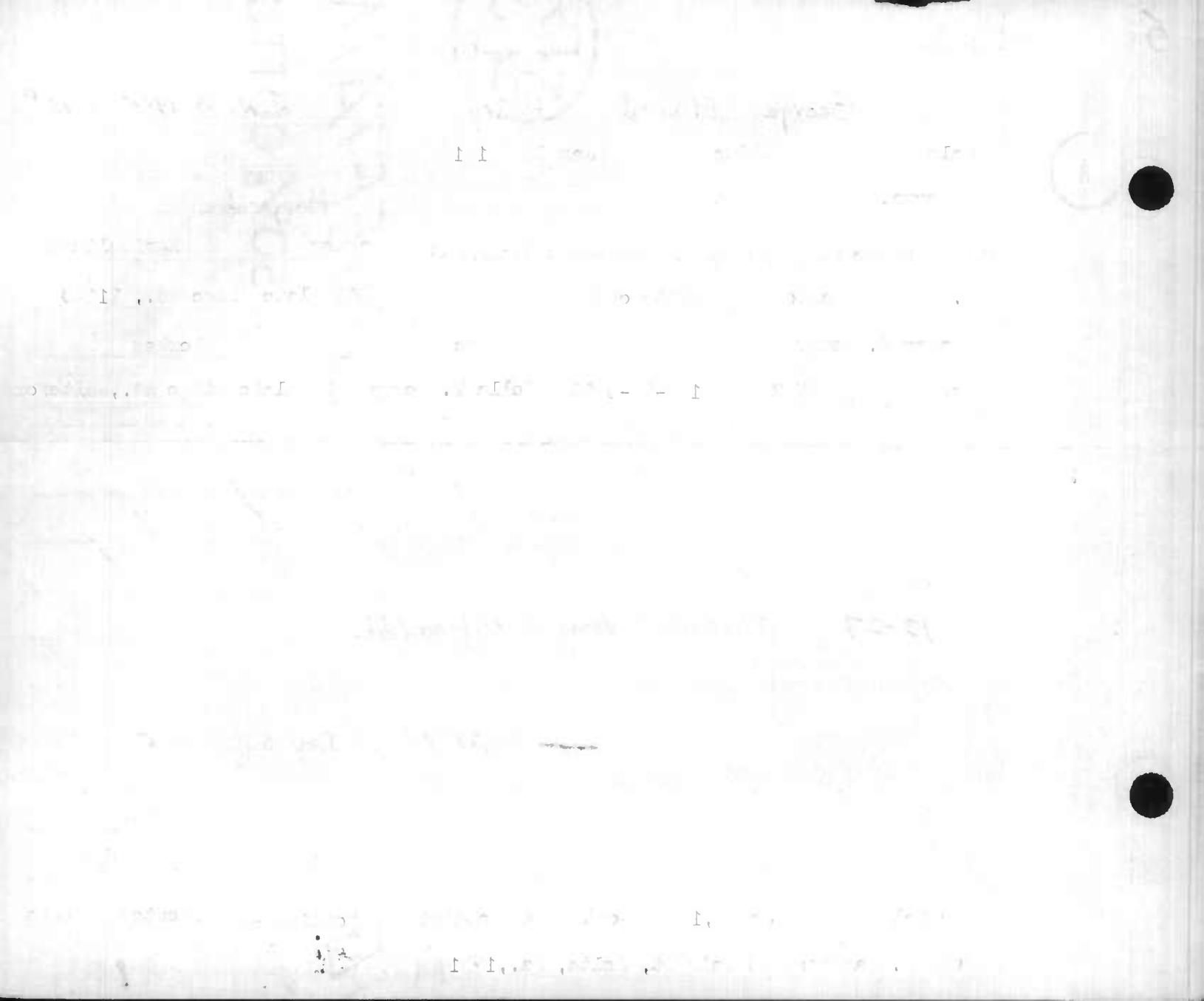


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IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502058						
1 - STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
George Elwood Henry									Jan. 3 1985				9:15 P			
3. SEX			RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Male			White			Jan 23 1916			68				MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford				IF UNDER 24 HRS MONTHS HOURS MIN.			
Penns.			USA										MD.			
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Harford Memorial Hospital			12a. USUAL OCCUPATION Farmer			12b. KIND OF BUSINESS OR INDUSTRY Agriculture							
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Whiteford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 4425 Slate Ridge Rd., 21160			
14. FATHER'S NAME James S. Henry			15. MOTHER'S MAIDEN NAME Eva										LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 2			17. INFORMANT Della V. Henry			ADDRESS 4425 Slate Ridge Rd., Whiteford				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
10. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Car to respiratory arrest						
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic muscular sufficiency																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any																
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease & sufficiency																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.																
18. MEDICAL CERTIFICATION			19a. DATE OF OPERATION 12-27			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombolectomy of Rt. femoral artery			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 27 1984</u> to <u>JAN 3 1985</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here <input type="checkbox"/>																
22b. SIGNATURE John H. Harkins										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Harkins M.D. 319 S. Union Ave Hagerstown, Md. 21742										22d. DATE SIGNED 14/85						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 6, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Nottingham Baptist			23d. LOCATION CITY OR TOWN Nottingham				COUNTY		STATE	
24. FUNERAL DIRECTOR NAME John H. Harkins			ADDRESS 600 Main St., Delta, Pa., 17314						25a. DATE REC'D. BY REGISTRAR Jan 6, 1985				25b. REGISTRAR'S SIGNATURE John H. Harkins			

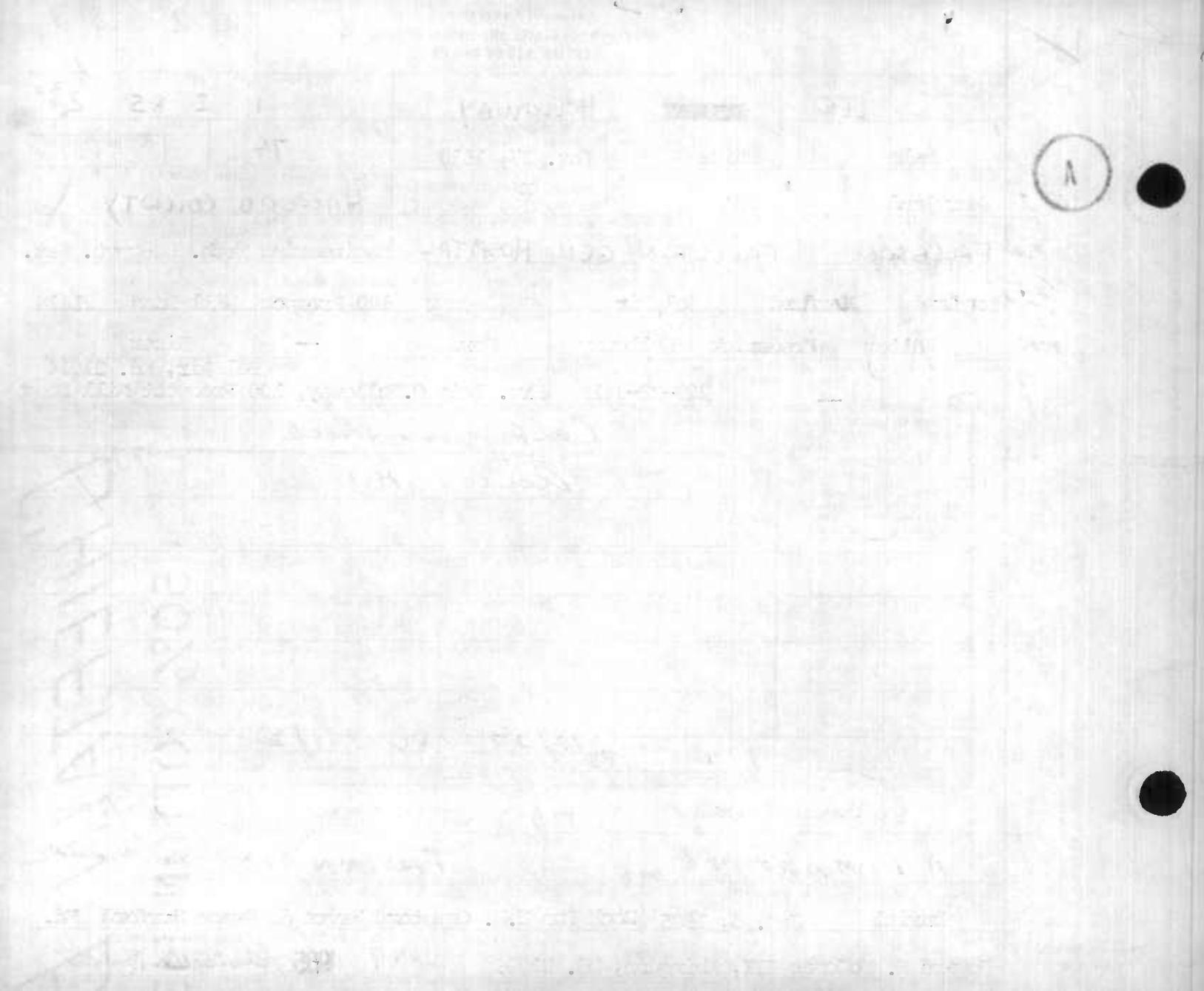


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked, or if Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 5 9							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
LEE STALEY HOLLOWAY						1 2 85			3:00 P.M.								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
Male		White		Oct. 27, 1910			74 YRS										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		USA					Harford County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Fallston		Fallston Gen. Hospital					Engineering Tech.			US-govt. Ret.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland		Harford		Bel Air						100 Prospect Mill Road 21014							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS									
		Walter	Frederick	Holloway	Nora			Bel Air, Md. 21014									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		220-22-0419					Mrs. Lois O. Holloway, 100 Prospect Mill Road			7 days							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.					Acute M.I.												
19. MEDICAL CERTIFICATION		20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			21d. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)															
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		12/27 1984		12/27 1984 to 12/27 1985													
22b. SIGNATURE		A. B. MARTINS MD		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			1/2/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			FALLSTON GENERAL HOSPITAL												
A. B. MARTINS MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE				
Burial		Jan. 5, 1985		Rock Run U.M. Cemetery			Havre de Grace			Harford			Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Howard K. McComas III, Abingdon, Md. 21009					JAN 7 1985			Julie Davidson Pendell									



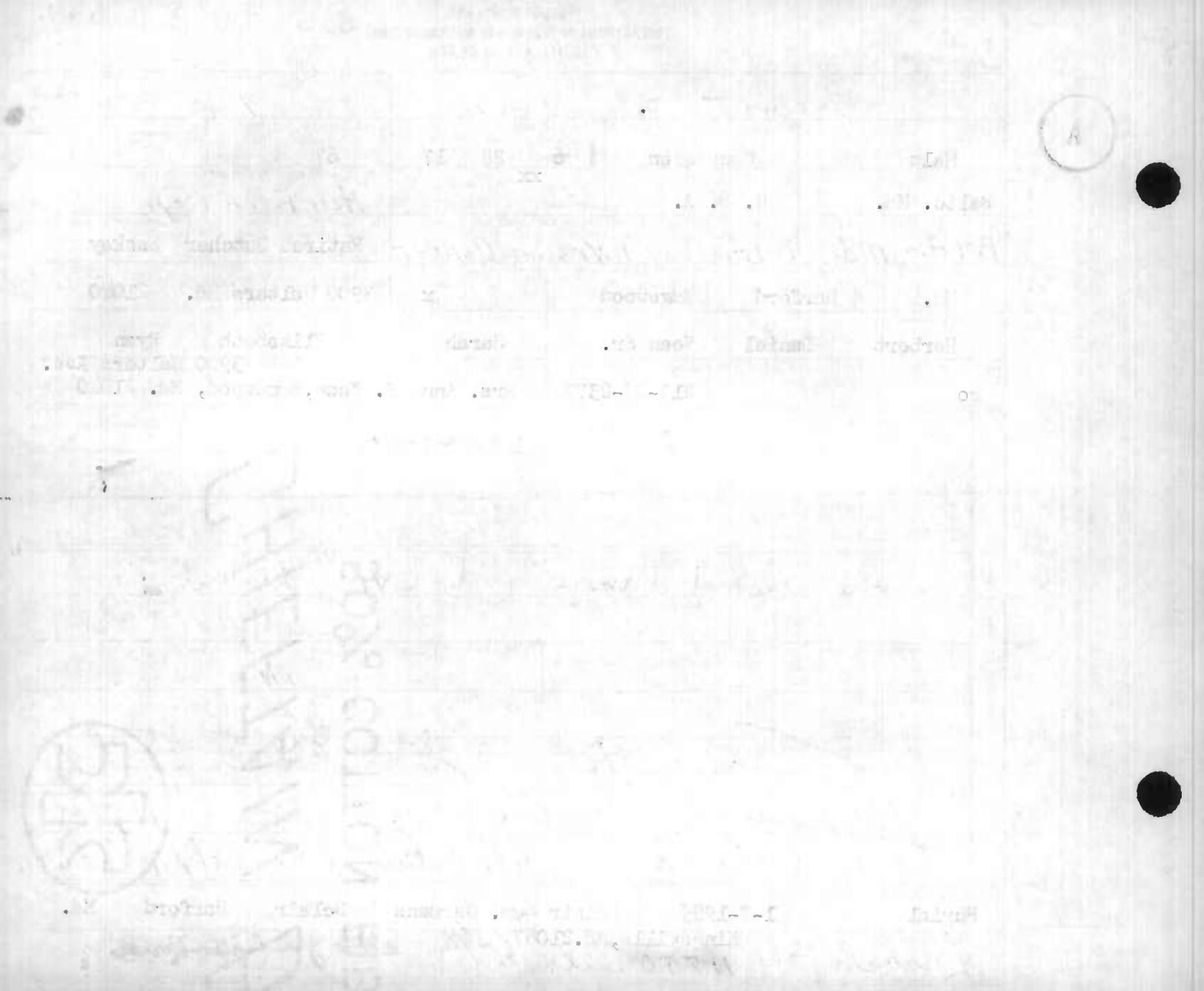
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the funeral director's permit. Then please remove carbon paper. Form 1 (dead 2 should be filled within 72 hours of death).

IMPORTANT: If item 21 is marked as item 18, show injury, injury or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Herbert D. Keen						1	5	85		4 20 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		Caucasian		MONTH	DAY	YEAR	67		MONTHS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED	<input type="checkbox"/>	YRS.	DAYS	HOURS	MIN.
Balto. Md.		U. S. A.		WIDOWED		DIVORCED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Bel Air Md.		Bel Air Conv. & Nursing Center						Retired Butcher			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		Harford		Edgewood		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	3900 Walters Rd. 21040			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Herbert	Daniel	Keen Sr.			Sarah	Elizabeth	Ryan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		213-05-2377		Mrs. Anne M. Keen, Edgewood, Md. 21040		3900 Walters Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>a mto pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Severe cerebral damage		20 b CVA, bilateral		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 3 1985</i> to <i>Jan 5 1985</i> , that (I) (we) last saw the deceased alive on <i>Jan 3 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bon Opeyza</i>											
22c. DEGREE <i>M.D.</i>											
22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22e. ADDRESS <i>1131 Baltimore Pike, Bel Air, Md. 21014</i>											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION		23e. BURIAL, CREMATION, REMOVAL			
Burial		1-7-1985		Belair Mem. Gardens		Belair		Harford		Md.	
24. FUNERAL DIRECTOR		25a. DATE		25b. NAME OF CEMETERY OR CREMATORIAL		25c. LOCATION		25d. DATE		REGISTRAR'S SIGNATURE	
Lascash FH		Kingsville, Md. 21087		Belair Ref.		Belair		Harford		MD. 21040	
25e. DATE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502061			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
George Herman Kenly						Jan 6 1985			9:05 P				
3. SEX Male			RACE Black			5. DATE OF BIRTH MONTH DAY YEAR November 1, 1911			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.				
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10. CITY OR TOWN OF DEATH Harford Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Rail Roads			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST George Wesley Kenly			15. MOTHER'S MAIDEN NAME Haddie Jane Hollingsworth			13e. STREET ADDRESS / ZIP CODE 432 Dorsey Street 21001			ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 705-09-6880			17. INFORMANT Dora Broadwater, 432 Dorsey St., Aberdeen, Md. 21001			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, Part 2, Part 3) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia +			DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Congestive Heart Failure													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FAIR, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from the deceased alive on 1/6/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.			22b. DEGREE Danth. M. Mahlms.			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/6/85				
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE M. MARCHIL			22e. ADDRESS 622 S. Union Ave, Aberdeen, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 11, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Union United Cemetery			23d. LOCATION CITY OR TOWN Aberdeen				
24. FUNERAL DIRECTOR NAME Terry Funeral Home, P.A., Aberdeen, Md. 21001-3399			25a. ADDRESS Terry Funeral Home, P.A., Aberdeen, Md. 21001-3399			25b. DATE REC'D. BY REGISTRAR JAN 11 1985			25c. REGISTRAR'S SIGNATURE L. Wilson Pendell				

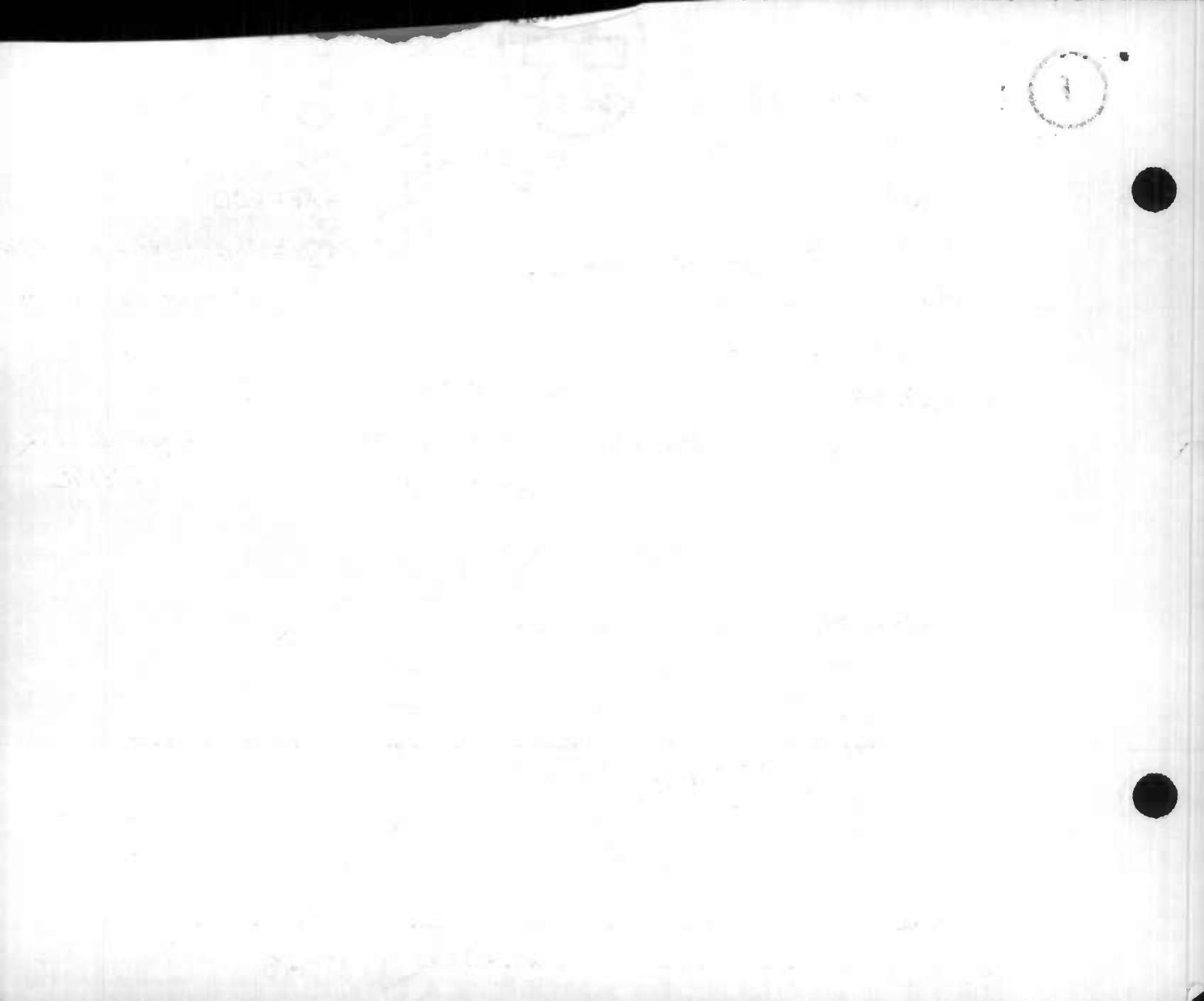


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 02062															
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2. FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
CHARLES J. KOLBE						Jan 18 85									
3. SEX MALE			4. RACE W			5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 20			6. AGE (IN YEARS) 64			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			10. CITY OR TOWN OF DEATH FOREST HILL			
												11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 317 Whetstone Rd.		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) BUSINESSMAN	
13a. STATE Md			13b. COUNTY HARFORD			13c. CITY OR TOWN FOREST HILL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE 317 WHETSTONE RD, 21050		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
14. FATHER'S NAME Charles A. Kolbe									15. MOTHER'S MAIDEN NAME Marie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No UNKNOWN			16b. SOCIAL SECURITY NO. 219-03-2340			17. INFORMANT WIFE			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES / 1 YR						
												CARBON MONOXIDE POISONING - TERMINAL CANCER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DEPRESSION			CHRONIC						
			DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION APRIL '84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED COLON CANCER			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED —			21d. NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —									
22a. I certify that (I) this hospital attended the deceased from 12-13 1984 to 1-17 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 1-17 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death															
22b. SIGNATURE Perfecto C. Valarao			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1-18-85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PERFECTO C. VALARAO, MD			22e. ADDRESS 1716 HARFORD RD, FALLSTON MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Entombment			23b. DATE 1-21-85			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.			23d. LOCATION CITY OR TOWN Balt. Md. COUNTY STATE						
24. FUNERAL DIRECTOR J. H. C. Miller Inc-6415 Belair Rd.-21206			25a. DATE REC'D. BY REGISTRAR JAN 22 1985			25b. REGISTRAR'S SIGNATURE Julia Sanderson Rendell									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner  
should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 6 3			
1 - STATE REGISTRAR											REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
RICHARD E. LOGAN									1 26 85						2-25pm
3. SEX MALE			4. RACE BLACK			5. DATE OF BIRTH MONTH 3 DAY 3 YEAR 06			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE COUNTRY Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			MONTHS		DAYS	
10. CITY OR TOWN OF DEATH HAVRE-DE-GRAVE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CITIZENS NURSING HOME			12a. USUAL OCCUPATION - (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY			MD.			
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN HavreDeGrace			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 811 Garfield Road 21078			
14. FATHER'S NAME FIRST James			MIDDLE Edward			LAST Logan			15. MOTHER'S MAIDEN NAME FIRST Addie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 225-20-6962			17. INFORMANT Eva Mae Logan same as above			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for item (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
AS 000 & Cardiac decompression Due to, or as a consequence of (b) <i>Pulmonary</i> Due to, or as a consequence of (c) <i>Permanent pace maker</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-3 19 84 to 1-26- 19 85, that (I) (we) last saw the deceased alive on 1-24- 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1-26-85			
22b. SIGNATURE Lee			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME, TITLE OR RANK Lee			22e. ADDRESS Lemon Med Clinic Havre De Grace												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/30/85			23c. NAME OF CEMETERY OR CREMATORIAL St. James Cemetery			23d. LOCATION CITY OR TOWN HavreDeGrace			COUNTY Harford	STATE Md.		
24. FUNERAL DIRECTOR NAME Arnold Beard 353 Fountain St. ADDRESS HavreDeGrace, Md.												25a. DATE REC'D. BY REGISTRAR/25b. REGISTRAR'S SIGNATURE JAN 29 1985 Lauren Kendall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 5 0 2 0 6 4
					REG. NO.
1. FOR STATE REGISTRAR	2. DECEASED NAME (TYPE OR PRINT)			3. DATE OF DEATH MONTH DAY YEAR	
	WILLIAM EDWARD LUSBY			January 20, 1985	
3. SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		2b. HOUR 5:18 P.M.
Male	White		June 25, 1889		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.
Maryland	USA				
10. CITY OR TOWN OF DEATH Edgewood	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1928 Bayberry Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Operator	
Maryland	13a. STATE Harford	13b. COUNTY Edgewood	13c. CITY OR TOWN Edgewood	12b. KIND OF BUSINESS OR INDUSTRY Marina	
14. FATHER'S NAME John	FIRST —	MIDDLE —	LAST Lusby	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no —		13e. STREET ADDRESS 1928 Bayberry Road 21040		13e. STREET ADDRESS Edgewood, Md. 21040
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CARDIOVASCULAR DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Eric Fisher</u>					
22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 1-21-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Fisher, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Jan. 23, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Olivet Church Cemetery		23d. LOCATION CITY OR TOWN Olivet COUNTY Calvert STATE Md.
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JAN 22 1985		25b. REGISTRAR'S SIGNATURE JAN 22 1985	
DHMH - 16 50M 4/82 (VRA 15, 4)					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02065

FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

John

MIDDLE

LAST

REG. NO.

2. SEX

4. RACE

Male

White

5. DATE OF BIRTH  
MONTH DAY YEAR

Jan. 15, 1937

6. AGE (IN YEARS  
LAST BIRTHDAY)

47 yrs.

7. IF UNDER 1 YR.

MONTHS

8. IF UNDER 24 HRS

DAYS

9. MARRIED

HOURS

10. DEATH  
ESTI-  
MATED

MIN.

11. DATE  
PRONOUNCED  
DEAD

MONTH DAY YEAR

12. DATE  
REG. NO.

MONTH DAY YEAR

13. DEATH  
MATED

1 5 19 85

M

2d HOUR

14. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Fallston, Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED

NEVER MARRIED

9. WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Harford County,

MD

10. CITY OR TOWN OF DEATH

Fallston

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Cust. Service Engr. Mch. Repair

13a. STATE

Maryland

13b. COUNTY

Harford

13c. CITY OR TOWN

Edgewood

13d. INSIDE CITY LIMITS?

YES NO 

13e. STREET ADDRESS

2419 Sycamore Drive 21040

14. FATHER'S NAME

Ernest

MIDDLE

Barbour

LAST

Maddox

15. MOTHER'S MAIDEN NAME

Hazel

MIDDLE

Marie

LAST

Amos

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

Korea

16b. SOCIAL SECURITY NO.

218-32-3271

17. INFORMANT

Mrs. Karen S. Green, 103-J Waldon Road, Abingdon, Md. 21009

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Traumatic injuries &amp; Cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES  NO 

21a. EXTERNAL CAUSE WAS

UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Driver in auto/fixed object impact

21d. INJURY OCCURRED

WHILE  NOT WHILE AT WORK  AT WORK 21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

Md Harford

22a. I certify that I took charge of the remains described above, held on

death resulted from: Natural causes Accident Autopsy Inspection Inquiry 

and in my opinion

Suicide Homicide Undetermined manner 

TITLE (SPECIFY)

ACTUAL SIGNATURE

Thomas D. Smith, M.D.

19. MEDICAL EXAMINER

DATE SIGNED 1/6/85

EXAMINER'S NAME  
(TYPE OR PRINT)

ADDRESS 111 Penn St.

Balto., MD

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Cremation

23b. DATE

Jan. 8, 1985

23c. NAME OF CEMETERY OR CREMATORY

Cratin-Ferris Crematory

23d. LOCATION

W. Chester

CITY OR TOWN

Chester

COUNTY

Penns.

24. FUNERAL DIRECTOR

NAME

Howard K. McComas III,

ADDRESS Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR

JAN 8

25b. REGISTRAR'S SIGNATURE

John D. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 6 6											
												REG. NO.											
1 - FOR STATE REGISTRAR																							
1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE (mn)		LAST Markovich		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
John		John		(mn)		Markovich		January 16, 1985		4:40		PM											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS													
Male		White		MONTH May 16, 1902		YEAR		MONTH		DAYS		HOURS		MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																	
Thomas, W.Va.		USA				Harford County																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Fallston		1011 Main Street		M/Sgt.		USMilitary - Ret.																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE															
Maryland		Harford		Fallston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1011 Main Street		21047													
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST													
FIRST Sam		---		Markovich		FIRST Mary		---		(Unknown)													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
Yes		WWII		576-26-7739		Sybil I. Lovelance, Stewartstown, Pa.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																							
PART 1. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>																							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart Disease</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-85</u> to <u>1-10-85</u> , that (I) (we) last saw the deceased alive on <u>1-10-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED									
22b. SIGNATURE <u>Joseph Reinhardt for Dr. Vassar</u> DEGREE														Jan. 17, 1985									
22e. ADDRESS																							
Joseph A. Reinhardt, M.D.														2003 Rock Spring Road, Forest Hill, Md. 21050									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE											
Burial			Jan. 19, 1985			Bel Air Memorial Gardens, Bel Air		Harford															
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Howard K. McComas III, Abingdon, Md. 21009						JAN 18 1985																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows only injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

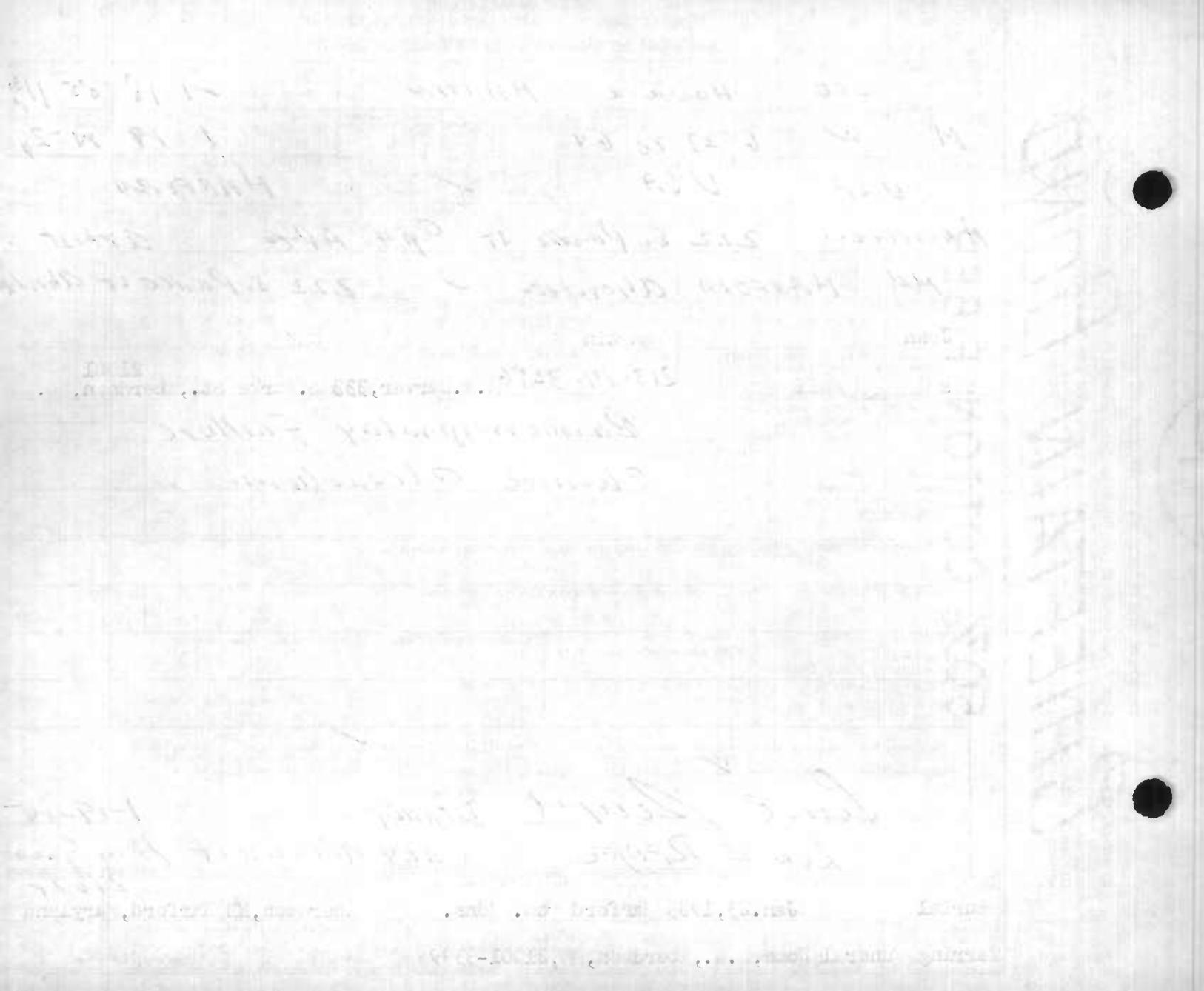
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 6 /			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Harry Leslie Martin						January 7, 1985			6 a m				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				
Male			White			8 19 1913			71 YRS				
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
Virginia			U.S.A.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bel Air			2054 Cabot Court			Head Pickler			Beth. Steel				
13a. STATE Maryland			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7941 St. Gregory Dr. 21222				
13c. CITY OR TOWN Dundalk													
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Walker Martin			Sarah Byran										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			213-09-0289			Ida Rose Martin			Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the LUNG</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>10-5-77</u> , 19 <u>85</u> , to <u>1-7-85</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>12-25-85</u> , and that in my <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (We) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jose Ardaiz</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>1-7-85</u>				
22e. ADDRESS <u>7838 EASTERN AVE. BALTIMORE, MD.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>1/9/1985</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Gardens Of Faith</u>			23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>21222</u> STATE <u>MARYLAND</u>				
24. FUNERAL DIRECTOR <u>Duda-Ruck, Inc.</u> NAME <u>Jose Ardaiz</u> ADDRESS <u>7922 Wise Avenue Dundalk, MD. 21222</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 9 1985</u> REGISTRAR'S SIGNATURE <u>Jula Davidson-Pendall</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3 AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												85	02068						
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN MONTH DAY YEAR			2b. HOUR				
Leo			Hawera			MARTIN						01 18 1985			11:30				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED MONTH DAY YEAR			2d. HOUR		
M		W		6 27 20			64 yrs.							1 19 1985			2:15		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			10b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
USA			USA			<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			HARFORD			222 S. Parke St			Ap 4 Apte			Artist	
10c. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Aberdeen			222 S. Parke St			Ap 4 Apte			YES <input checked="" type="checkbox"/>			222 S. Parke St. Aberdeen			John Martin			UNK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes WWII			213-14-3296			R. M. Carver, 222 S. Parke St., Aberdeen, MD.			Pulmonary respiratory failure										
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF						(b) Chronic alcoholism										
			DUE TO, OR AS A CONSEQUENCE OF						(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		Lew E. Renfry M.D. Deputy MEDICAL EXAMINER										TITLE (SPECIFY)							
EXAMINER'S NAME (TYPE OR PRINT)		Lew E. Renfry										ADDRESS 464 Allaire St. Harford, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE				
Burial			Jan. 23, 1985			Harford Mem. Gdns.			Aberdeen, MD			Harford, Maryland			21071				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399						Jan 28 1985			Lew E. Renfry										
BP						DHMH - 17						(VR A) 5 ME (5)							

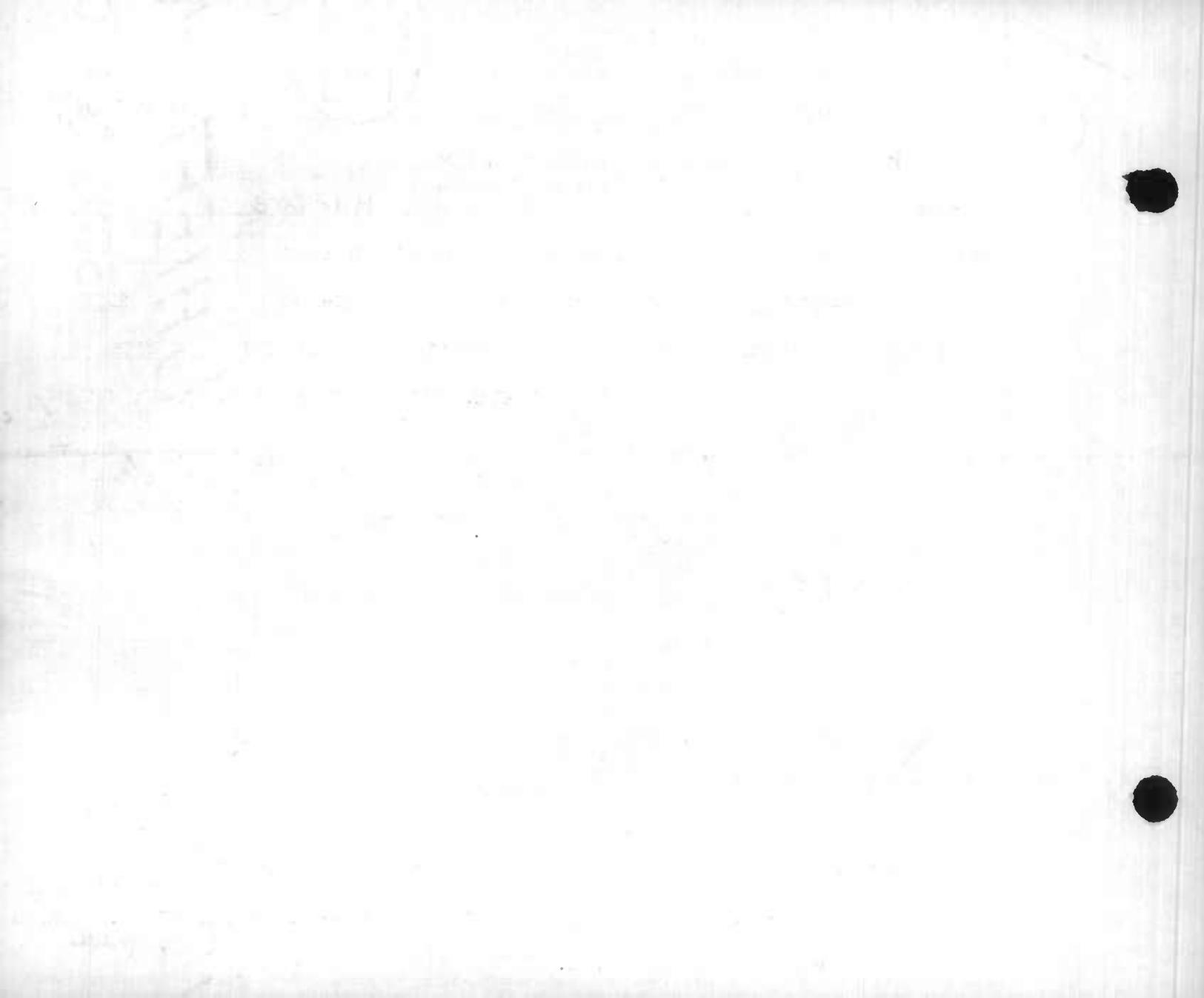


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If item 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 2 should be detached for use as the Burial/Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 'CERTIFICATE OF DEATH'										8502069		
1 - STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Clara Lillian Mentzer						1 31 85			10 55 AM			
3. SEX <b>F</b>		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 11, 1894			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.		
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BERN DRIVE 21078			
14. FATHER'S NAME FIRST CHARLES		MIDDLE MAURICE		LAST JONES			15. MOTHER'S MAIDEN NAME FIRST MARGARET		MIDDLE ELIZABETH		LAST DAVIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212 74 3903		17. INFORMANT JAMES C. MENTZER 505 PLUMBTREE RD. BEL AIR, MD 21014						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												
DUE TO OR AS A CONSEQUENCE OF <i>Advanced arteriosclerosis cardio-vascular disease</i>												
DUE TO OR AS A CONSEQUENCE OF <i>Obstructive or biliary obstruction</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Hypertension</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) not view the body after death, _____)												
22b. SIGNATURE <i>H. Yamakawa M.D.</i> DEGREE												
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>2/1/85</i>										
22e. ADDRESS <i>319 So. Union Ave. Havre de Grace</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4 FEBRUARY 85		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MARYLAND					
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR FEB 4 1985			25b. REGISTRAR'S SIGNATURE <i>Mitchell</i>							



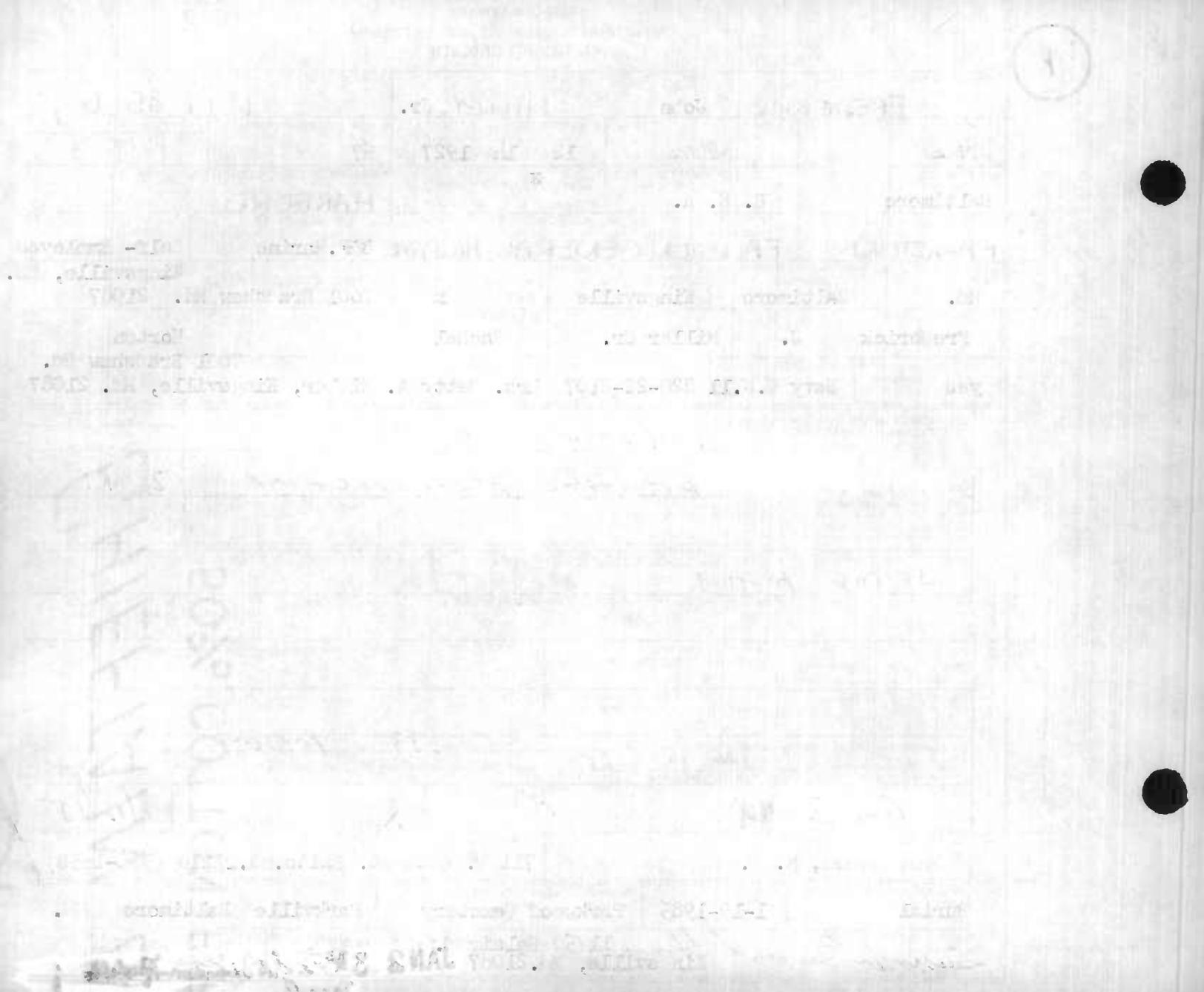
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

remained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or Item 18 shows any injury, list other non-fatal injury, list other non-fatal event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	02070		
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
FREDERICK			John		MILLER Jr.	1 17 85					1785	6 32 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 2 YEARS				
MALE		WHITE		MONTH 12 DAY 14 YEAR 1927			57			MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH									
Baltimore		U. S. A.		X NEVER MARRIED DIVORCED			HARFORD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
FALSTON		FALLSTON GENERAL HOSPITAL		B&F. Marine			Self-Employed			Kingsville, Md.						
13a. STATE Md.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7601 Bradshaw Rd. 21087									
14. FATHER'S NAME Frederick J. Miller Sr.				15. MOTHER'S MAIDEN NAME Rachel						ADDRESS 7601 Bradshaw Rd.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN		16b. SOCIAL SECURITY NO. Navy W.W.11 220-22-2107		17. INFORMANT Mrs. Betty A. Miller, Kingsville, Md. 21087						Horton						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPPIRATORY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		(b) METASTATIC ADENO CARCINOMA								2 yrs						
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
SEVERE ANEMIA																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from 19 83 to PRESENT 19 , that (1) (we) last saw the deceased alive on Jan 10 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE G. I. C.		22c. DEGREE MD		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/18/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Cohen, M. D.		22e. ADDRESS 711 W. 40th St. Balto. Md. 21210 (366-1838)														
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1-19-1985		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION CITY OR TOWN Parkville			COUNTY Baltimore		STATE Md.				
24. FUNERAL DIRECTOR Name Ernest Funeral Home		25a. DATE REC'D. BY REGISTRAR 11750 Belair Rd.		25b. REGISTRAR'S SIGNATURE Kingsville, Md. 21087												



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

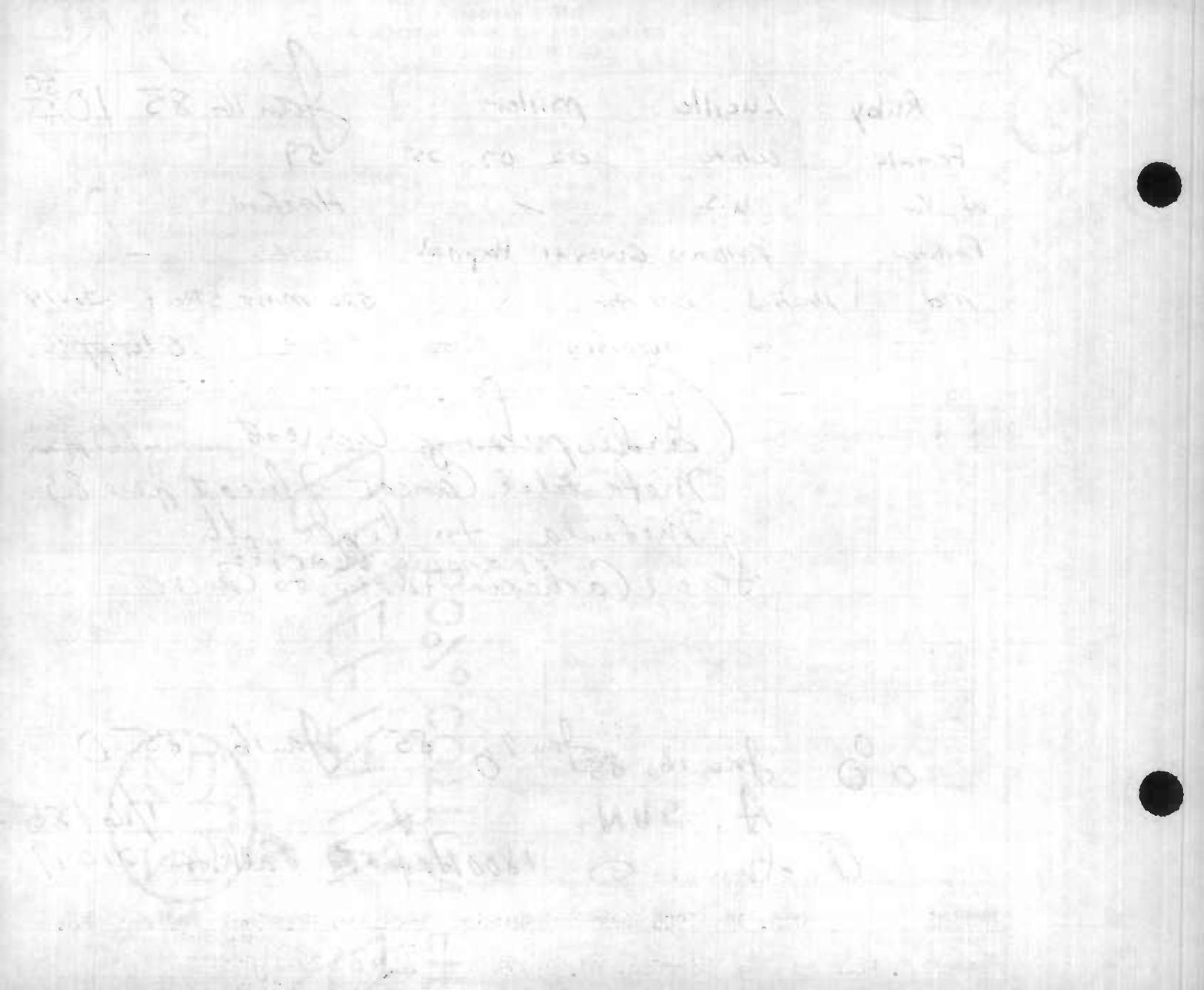
IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REC. NO.

8 5 0 2 0 7 1

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	50			
Ruby Lucille Miller						Jan. 16, 85				10A	M			
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		UNDER 7 DAYS			
Female		white		MONTH	DAY	YEAR	59			MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
W. Va.		U.S.							Harrowd					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston		Fallston General Hospital		Housewife										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
Md		Harrowd		Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		520 Main Street 21014						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		LAST Clutter Gibboppe			
		Harry	Thomas	Morrison	Glenna Catherine		215-34-7203		Robert E. Miller, 1716 Ironwood Court, Edgewood		Md. 21040			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND		
		DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of breast Jan 83										70A		
		DUE TO, OR AS A CONSEQUENCE OF (c) Metastasis to liver with Severe Cachexia related to Cancer												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE LEADING CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		22a. DATE SIGNED								
						1/16/85								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from		Jan. 16, 1985, to		Jan. 16, 1985, that (I) (we) lost										
saw the deceased alive on		Jan. 16, 1985		and that in my (our) opinion death occurred on the date and hour and from the causes stated										
above (I/we) did (did not) view the body after death														
22b. SIGNATURE		A. Sun.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		1/16/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		C. Sun. III		22e. ADDRESS		1800 Harford Rd Fallston 21047								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		Jan. 18, 1985		Harrowd Baptist Cemetery, Harrowd, Balto		Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Howard K. McComas III, Abingdon, Md. 21009				JAN 21 1985		John J. McComas								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed by the hospital or attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502072			
										REG. NO.			
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
I. DECEASED NAME FIRST MIDDLE LAST			JAN. 14 <sup>th</sup> , 1985 11 13 AM										
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
MALE		White		10 23 19			-65-			YRS			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Hugo MINNESOTA		UNITED STATES					HARFORD County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
FALLSTON		FALLSTON General Hospital							US Government			INSPECTOR	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2824 Dublin Rd 21154			
MARYLAND		HARFORD		STREET									
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
Dr. Francis E.		MINGO, M.D.		Agnes									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (WIFE) 836-1669 ADDRESS Mrs. Lois T. Mingo 2824 Dublin Road									
Yes - Army		W.W.2		721-03-7928						STREET, MARYLAND (21154)			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7h			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).										DUE TO, OR AS A CONSEQUENCE OF (b)			
DUE TO, OR AS A CONSEQUENCE OF (c)										Massive M.S.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Massive cerebrovascular accident										3 day			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19							21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/14 8 AM to 1/14 9 AM, that (I) (we) last saw the deceased alive in 1/14 8 AM, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did) not view the body after death.										22b. SIGNATURE M. D.			
22d. PHYSICIAN'S NAME (SURNAMES)		23c. ADDRESS 1716 Harford Road							22c. DATE SIGNED 1-14-85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE JAN 16, 1985		23c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius Cath. Ch. Cem.			23d. LOCATION CITY OR TOWN Forest Hill, Harford Co., Maryland 21050						
Burial													
24. FUNERAL DIRECTOR Joseph William Foster		50 W. Broadway & Williams St Baltimore, Maryland 21014							25a. DATE REC'D. BY JAN 16 1985			25b. REGISTRATION NUMBER John Weller - 1047	
Tannerville, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/Transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 7 3											
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Lester			NMN			Montgomery						1 5 85			3 AM								
3. SEX		4. RACE			5. DATE OF BIRTH			MONTH			DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
MALE		WHITE			8 11 12								72 YRS			MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
VA.		USA			WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>			Harford												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
Harve de Grace		Harford Memorial Hospital			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Md.		Harford			14. FATHER'S NAME FIRST			15. MOTHER'S M AIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT			21078						
JAMES		GARFIELD Montgomery ROSETTA			LAST						232-14-9792			GRACIE Montgomery (SAME)			241 Bloomberg Ave						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
NO		--			Respiratory Arrest w/ Marnine																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		1b)			DUE TO, OR AS A CONSEQUENCE OF Pul. metastasis &																		
		1c)			DUE TO, OR AS A CONSEQUENCE OF Renal failure																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 26</u> , 1984, to <u>1-5</u> , 1985, that (I) (we) last saw the deceased alive on <u>12-28-1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE			Muri Mathur MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Muri Mathur			22e. ADDRESS			3075 Union Ave., Harve de Grace, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE											
Burial			1-8-85			NORTH EAST METHODIST Cemetery			North East Cecil														
24. FUNERAL DIRECTOR NAME			Rising Sun Mort.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
RT FOARD FUNERAL HOME						21411			JAN 9 1985			John Davidson											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Item 1 and 2 should be filled within 24 hours.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called in advance.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8502074

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Blake			EDGAR	OWEN		1-28-85				5:02 AM	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
Male		White	MONTH	DAY	YEAR	60	IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Rugby, Va.		USA				Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hospital			Technician					US-govt. Ret	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			MD.	
Maryland		Harford	Fallston		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	5 Reckord Road			21047	
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST		
Grover		Marvin	Owen		Celia		Jane		Reedy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WWII			224-20-2249			Mrs. Virgie Owen, 5 Reckord Road, Fallston, Md.		
21047											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
30 min											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Cerebro vascular accident</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
one week											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Mark Adelman</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/28/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARK ADELMAN</u>		22e. ADDRESS <u>FALLSTON GENERAL HOSPITAL</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 1, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Owen Family Cemetery		23d. LOCATION CITY OR TOWN Rugby		CITY OR TOWN Grayson		STATE Va.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 29 1985		25b. REGISTRAR'S SIGNATURE <u>Julie Davidson Pendell</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7

relinquished by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon return pages 1 and 2 should be filled within 72 hours after death should be detached for use as the burial/transit permit. Then please remove carbon return pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 7 5			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
CARRIE Beatrice Patchell						1-15-85			08 12 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		10-28-1891			93		YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Md.		U.S.A.					Harford						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE			
Hare de Grace		Hartford Mem. Hospital			Housewife			Home		303 Concord Apts. 21903			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Charles Henry Murphy		Bertha McGuirk											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS						
No		213-18-1059			Walter A. Patchell		P.O. Box 64 Charlestown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS DOD</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>DM</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>1-14-85</i> to <i>1-15-85</i> , that (I) (we) last saw the deceased alive on <i>1-15-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J.T. Lee</i>		22c. DEGREE <i>Mr. J.T. Lee</i>			22d. ATTENDING PHYSICIAN <i>John Med. Clinic</i>			22e. DATE SIGNED <i>15/85</i>					
22d. PHYSICIAN'S NAME (PRINT OR TYPE)													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-15-85		23c. NAME OF CEMETERY OR CREMATORIAL Cratin & Ferris			23d. LOCATION West Chester, Chester County, Pa.						
24. FUNERAL DIRECTOR NAME <i>Robert J. Lee</i>		ADDRESS <i>North East, Md.</i>		25a. DATE REC'D. BY REGISTRAR JAN 17 1985			25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendell</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified around the time of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 7 6														
1 - FOR STATE REGISTRAR			REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR										
Josephine			M			Peay			Peay			1 27 85				4:30 PM										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.											
Female			Black			5-28-1923			61 yrs.																	
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																	
S.C.			USA						HARFORD COUNTY MD.																	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
FAULSTON			FAULSTON GEN. HOSPITAL																							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE														
Md.			Harford			Edgewood			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			432 Gateshead CT 21040														
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S M AIDEN NAME FIRST			MIDDLE			LAST											
Ike			Peay						Beatrice			Harman														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																	
no									Patricia Lloyd 432 Gateshead Ct.																	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE STROKE															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (b) GRAND MAL SEIZURES.																										
DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																										
19a. DATE OF OPERATION DEC 12 1984 DEC 13 1985			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LAPAROTOMY (exploratory) EXPLORATORY LAPAROTOMY WITH THORACIC EXPLORATION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (I) (this hospital) attended the deceased from NOV 21 1984 to JAN 27 1984, that (I) (we) last saw the deceased alive on JAN 27 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22b. SIGNATURE A. J. Rice			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED JAN 27 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-1-85			23c. NAME OF CEMETERY OR CREMATORIUM Holly Hill Cem.			23d. LOCATION CITY OR TOWN Edgewood H.C. Md.			COUNTY			STATE											
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Pl			ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 1 1985			25b. REGISTRAR'S SIGNATURE John D. Rice																	

BP \_\_\_\_\_



20%  
COPPER  
14.5%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please attach carbon copies. Pages 1 and 2 should be filled within 72 hours after death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

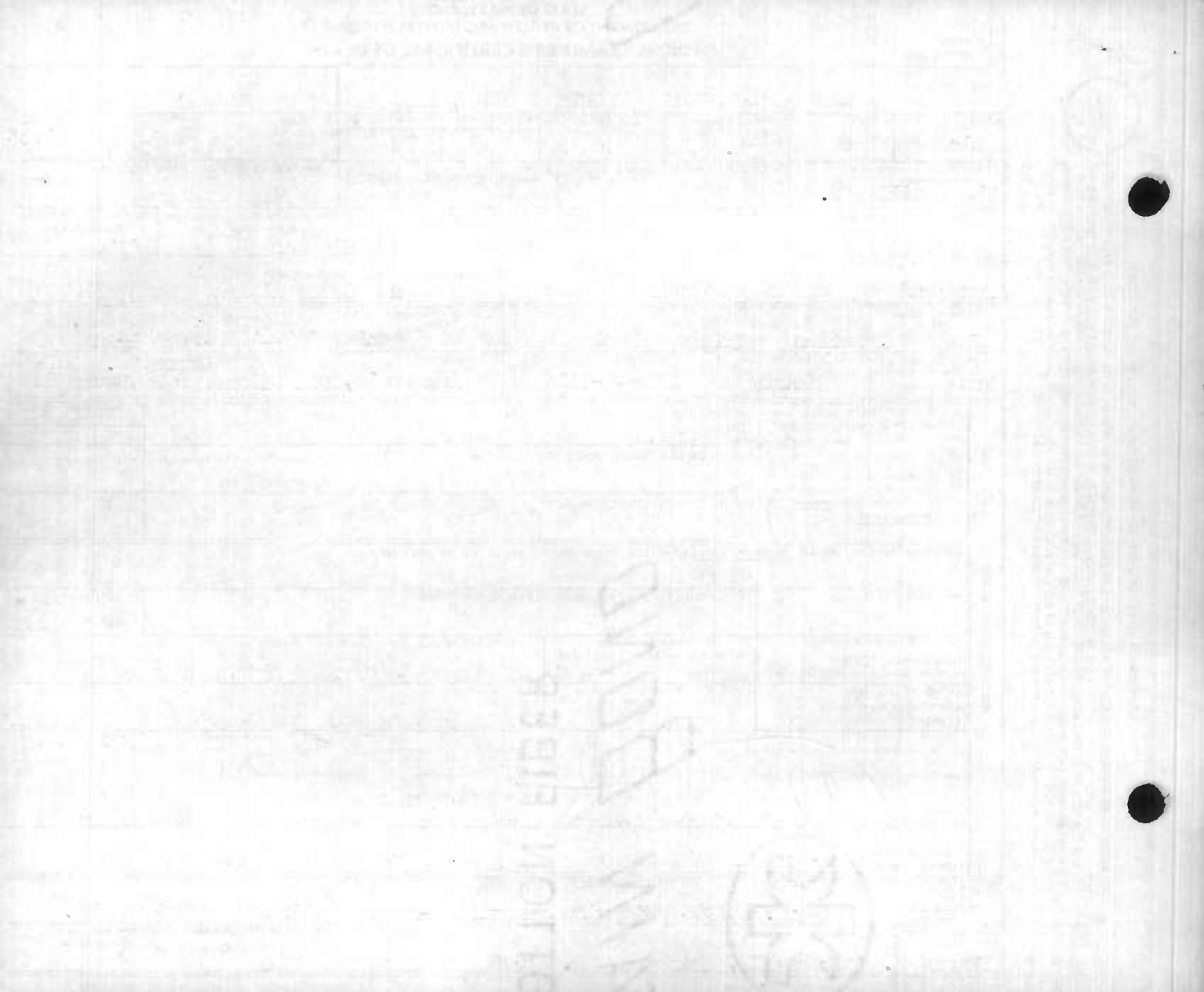
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 7					
												REG. NO.					
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)			Quy			Thi			Phung			1-19-85				3:00 A.M.	
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
FEMALE			VIETNAMESE			MONTH DAY YEAR			92			MONTHS	YEARS		MONTHS	YEARS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
VIETNAM			VIETNAM			July 15, 1892			Harford County			Housewife			Homemaker		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY					
Bel Air			Bel Air Nursing & Convalescent Center			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			452 East Broadway 21014			Housewife			Homemaker		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			Harford Co.			Bel Air (21014)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			452 East Broadway 21014			Housewife		
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME											
So			Phung			Phien											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Sex) 838-7568 Mr. Hoa The Nguyen			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			ADDRESS 452 East Broadway Bel Air, Maryland 21014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			586-48-0927						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral embolism					
									DUE TO, OR AS A CONSEQUENCE OF (b) cerebro vascular accident								
									DUE TO, OR AS A CONSEQUENCE OF (c) cerebral hemorrhage								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (1) this hospital attended the deceased from DEC. 24, 1984, to JAN. 19, 1985, that (2) we lost saw the deceased alive on JAN. 14, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we did (did not) view the body after death.																	
22b. SIGNATURE Ben Otey			22c. DEGREE M.D.			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			DATE SIGNED Jan. 19/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 1131 Baltimore Pike, Bel Air, Maryland 21014														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE January 21, 1985			23c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius Catholic Ch. Cem.			23d. LOCATION CITY OR TOWN Forest Hill, Harford Co., Maryland 21050			COUNTY			STATE		
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS 50 W. Broadway & William St Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR JAN 23 1985			25b. REGISTRAR'S SIGNATURE John Davidson Pendle								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 2 0 7 8			
				MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR			
JAMES IGNATIUS MECHEM				POOLE, II						<input checked="" type="checkbox"/>		1 24 1985		M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR 3:56 AM	
Male		White		Sept. 28, 1944		40 yrs.						1 24 1985					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Thomasville, Ga.		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Darlington		Rt. 161 SO. of Rock Run Rd.		Salesman		Auto			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Harford		Havre de Grace				3828 Wilkinson Road		21078							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
James Ignatius		Mechem		Poole		Naomi		Yes		219-42-5116		Rosina Poole, 3828 Wilkinson Rd, Havre de Grace, Md. 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma &amp; Chest compression</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
7 8150 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
		road		Rt. 161 SO. of Rock Run Rd., Darlington,						Md.							
22a. I certify that I took charge of the remains described above, herein death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>John Smith</i>		TITLE (SPECIFY) M.D. Acting Chief MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE							
Burial		Jan. 28, 1985		Highview Memorial Gardens, Fallston		Harford		Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Howard K. McComas III, Abingdon, Md. 21009				JAN 28 1985		<i>John Dawson</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the Burial-Transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 2 0 7 9			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR <u>12</u> <u>2 AM</u>			
Myrtle B					Poplar	1/17/85									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Female		White		MONTH	DAY	YEAR	79								
7b. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.					Harford								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY								
Harve de Grace		Harford Memorial Hospital					Homemaker								
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
				Harve de Grace				1028 Chesapeake Dr. 21078							
14. FATHER'S NAME: FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Franklin			M.	Baldwin	Emma					Leitheiser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			220-20-6383			Mr. James Poplar - Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Pulmonary Failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b): <u>Caronoma of Lung</u>															
DUE TO, OR AS A CONSEQUENCE OF (c):															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Congitive Heart Failure</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AS WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>1/12/85</u> 19 <u>85</u> to <u>1/12/85</u> 19 <u>85</u> , that (2) (we) last saw the deceased alive on <u>1/12/85</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>1/12/85</u>			
22b. NATURE <u>Dante Monakil</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANTE MONAKIL</u>			22d. ADDRESS <u>HARVE DE GRACE MD 21078</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 1/12/85			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23e. LOCATION CITY OR TOWN		23f. COUNTY		23g. STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR Balto., Md. <u>JAN 20 1985</u>			25b. REGISTRAR'S SIGNATURE <u>John K. Kishner, Jr.</u>									



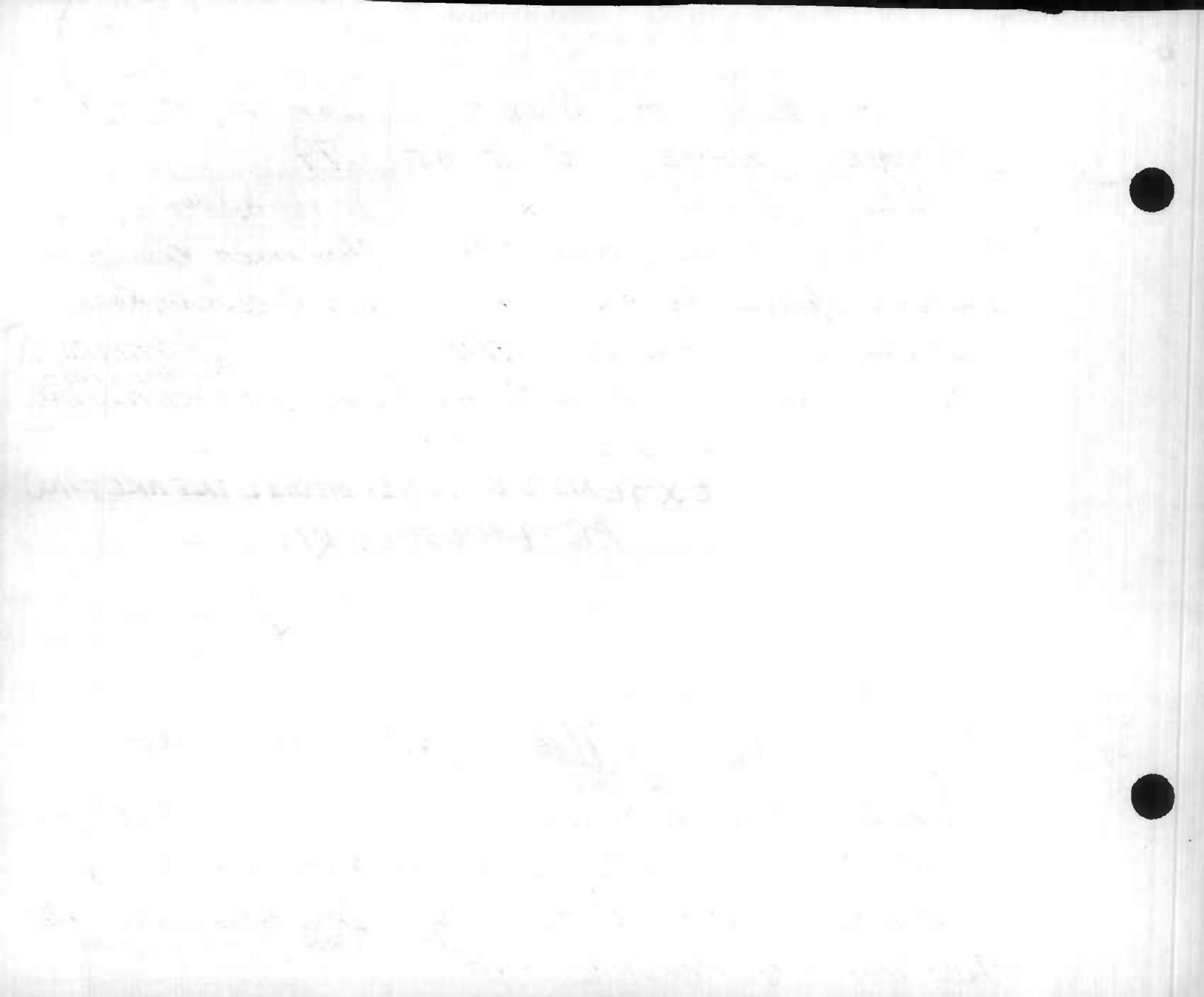
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 5 0 2 0 8 0					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR						
Puckett, Zita H			Puckett			Jan 20, 1985			12 35 PM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
FEMALE		WHITE		6 5 05			79								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
N.C.		U.S.A.					Harford County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace		Harford Memorial Hosp		HOMEMAKER			Own Home								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21014		
MARYLAND		HARFORD		BEL AIR						2116 ROBERTSON ROAD					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS			DARLINGTON, MD		
FOGAR				NAN			213-74-5446			RALPH G. PUCKETT 1754 WHITERIDGE RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardiac Arrest															
DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE MYOCARDIAL INFARCTION															
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/10, 1985, to 1/20, 1985, that (I) (we) last saw the deceased alive on 1/20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED	
22b. SIGNATURE Dante A. Monakil														DEGREE	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
DANTE A. MONAKIL			Havre de Grace, MD 21078												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
BURIAL			1-23-85			DARLINGTON			DARLINGTON & HARRER			MD			
24. FUNERAL DIRECTOR NAME			ADDRESS												
JOHN HARRINS 600 MAIN ST. DELTA PA															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 more be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8502081				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Elsie			Brown			Reed						JAN.	1-15-1985			3 A M
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			Caucasian			MONTH DAY YEAR			5 6 1888			96	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA									Harford County MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Bel Air			Bel Air Nursing Home			Homemaker										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland			Harford			Bel Air			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			410 MacPhail Rd., 21014				
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME							
George			W.			Brown			Cora			LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No			217-18-7275			Ruth R. Chisholm, Rt. #3 Box 219,			21550							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)																
PART 1. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiovascular accident</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u> cerebral thrombosis</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <u>JAN. 30 1985</u> to <u>JAN. 15 1985</u> , that (I) <u>we</u> last saw the deceased alive on <u>JAN. 14 1985</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> did <u>not</u> view the body after death.																
22b. SIGNATURE <u>BEN OLEYDA</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/15/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BEN OLEYDA</u> , M.D.			22e. ADDRESS <u>1131 Baltimore Pike Bel Air, Md. 21014</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/17/85			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.			23d. LOCATION CITY OR TOWN Pikesville			COUNTY Balto.		STATE Md.		
24. FUNERAL DIRECTOR NAME Bryan W. Clary, 10 W. Padonia Rd., 21093			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 17 1985			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							



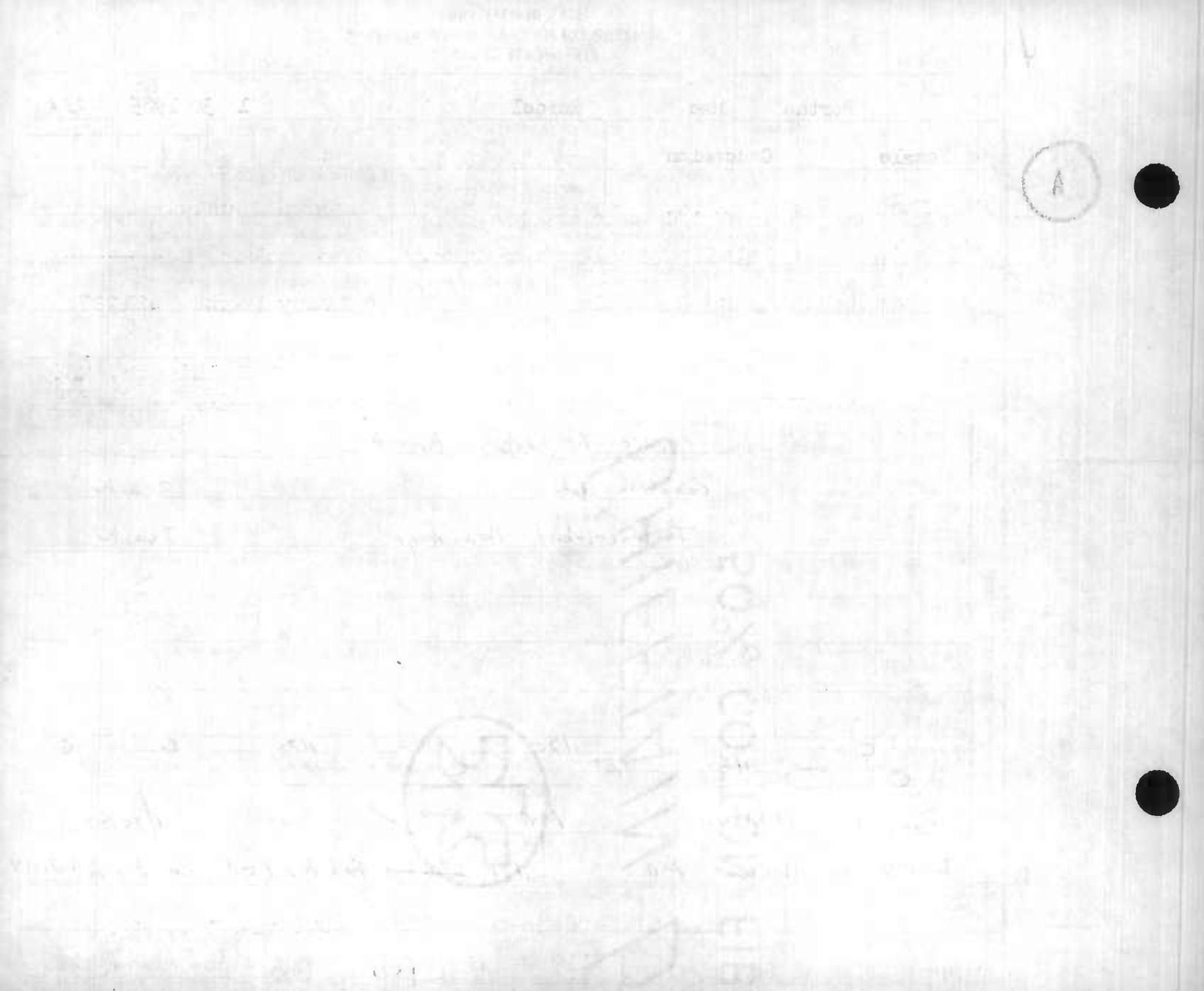
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, any injury, or other traumatic event

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502082			
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Bertha Mae Reidel						1 30 1985			3:38 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
Female		Caucasian		Nov 27, 1895			89 YRS						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.					Harford County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Belair		Belair Convalescent Cntr.					Home maker						
13a. STATE 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Baltimore Rosedale					8 Avery Court 21237						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William Baker		Montezuma Grant											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		212-09-5398		Florence Morgan			8 Avery Ct. 21237			Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Respiratory Arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Comatose state</u> 3 weeks													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracerebral Hemorrhage</u> 3 week													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 1/25, 1985, to 1/30, 1985, that (1) (I) lost saw the deceased alive 1/30, 1985, and that in (my) (1) (my) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DEGREE													
22c. DATE SIGNED													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			1/30/85					
DAVID W. McClure MD		1131 Winters Bel Air Road, Bel Air, Md 21019											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		Feb 2, 85		Gardens of Faith			Baltimore Co., Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Dippel Funeral Homes, Inc.		7110 Belair			FEB 1 1985			Julia Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at one:

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502083					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR				
William Thomas Robinson						1-1-85					1:12 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
MALE		White		11 11 99			85			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Harford Co., Md.		U. S. A.					Harford								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Fallston		Fallston General Hospital								Retired					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md.		Harford		Fallston						405 Whitaker Mill Rd. 21047					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Clarence				Robinson	Laura					Hecht					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS			405 Whitaker Mill Rd.					
no		220-34-7374					Mrs. Beverly Harris, Fallston, Md. 21047								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Age-related</u>										1d					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Spores</u>										2-30					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>UTI</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>30 Dec</u> , 19 <u>84</u> , to <u>1 Jan</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1 Jan</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (I) did not view the body after death.															
22b. SIGNATURE <u>Lassahn</u>		DEGREE <u>Mrs</u>								22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>1 Jan 85</u>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hassahn</u>		22f. ADDRESS <u>FGH</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1-4-1985		23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gar.			23d. LOCATION CITY OR TOWN Belair		23e. COUNTY Harford		STATE Maryland				
24. FUNERAL DIRECTOR E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02084

REG. NO.

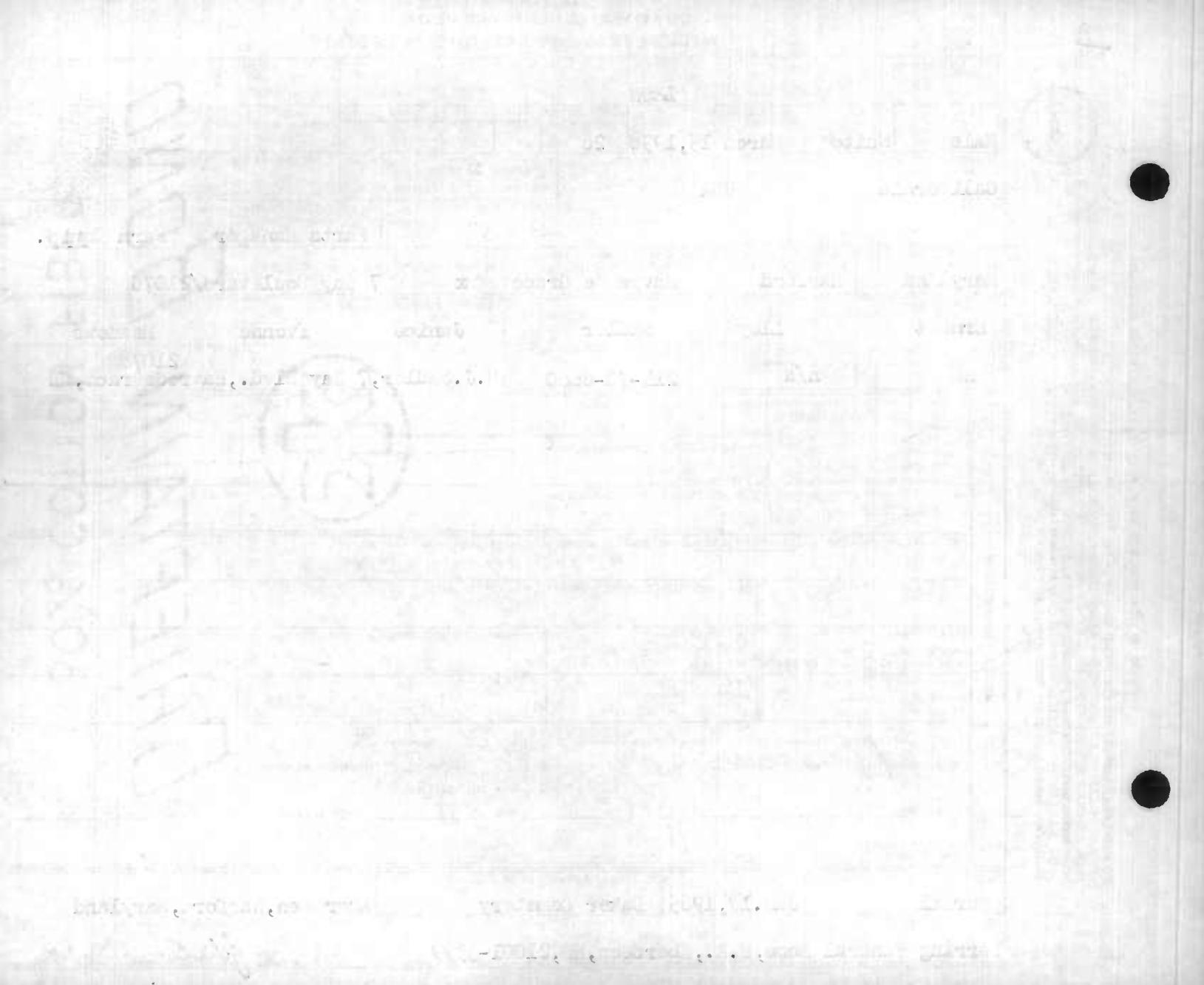
1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST ARTHUR	MIDDLE HENRY	LAST ROWE	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	MONTH JAN	DAY 1	YEAR 1985	2b. HOUR 6:00M P					
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH MARCH	DAY 6, 1915	YEAR 69	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	7c. DATE PRONOUNCED DEAD JANUARY 1, 1985	MONTH JAN	DAY 1	YEAR 1985	2d. HOUR 9:00M P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD
10. CITY OR TOWN OF DEATH HAVRE de GRACE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 289 WILSON STREET			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER			12b. KIND OF BUSINESS OR INDUSTRY BOARDING HOUSE							
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 289 WILSON STREET		21078								
14. FATHER'S NAME FIRST HENRY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROWE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 066 16 0769			17. INFORMANT ELSIE J. ROWE		ADDRESS SAME AS 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.															
(b) <u>ASCV</u> DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input type="checkbox"/> and in my opinion death resulted from: <u>Not natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>															
ACTUAL SIGNATURE <i>L. Renjel</i>		TITLE (SPECIFY) M.D.		Deputy		MEDICAL EXAMINER		DATE SIGNED 1-2-85							
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		ADDRESS 464 Alliance St. Havre De Grace, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 23JANUARY85		23c. NAME OF CEMETERY OR CREMATORIAL CRATIN & FARRIS			23d. LOCATION CITY OR TOWN WEST CHESTER,		COUNTY PA.		STATE PA.				
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD 21078		25a. DATE REC'D. BY REGISTRAR JAN 3 1985			25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson Rands</i>										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

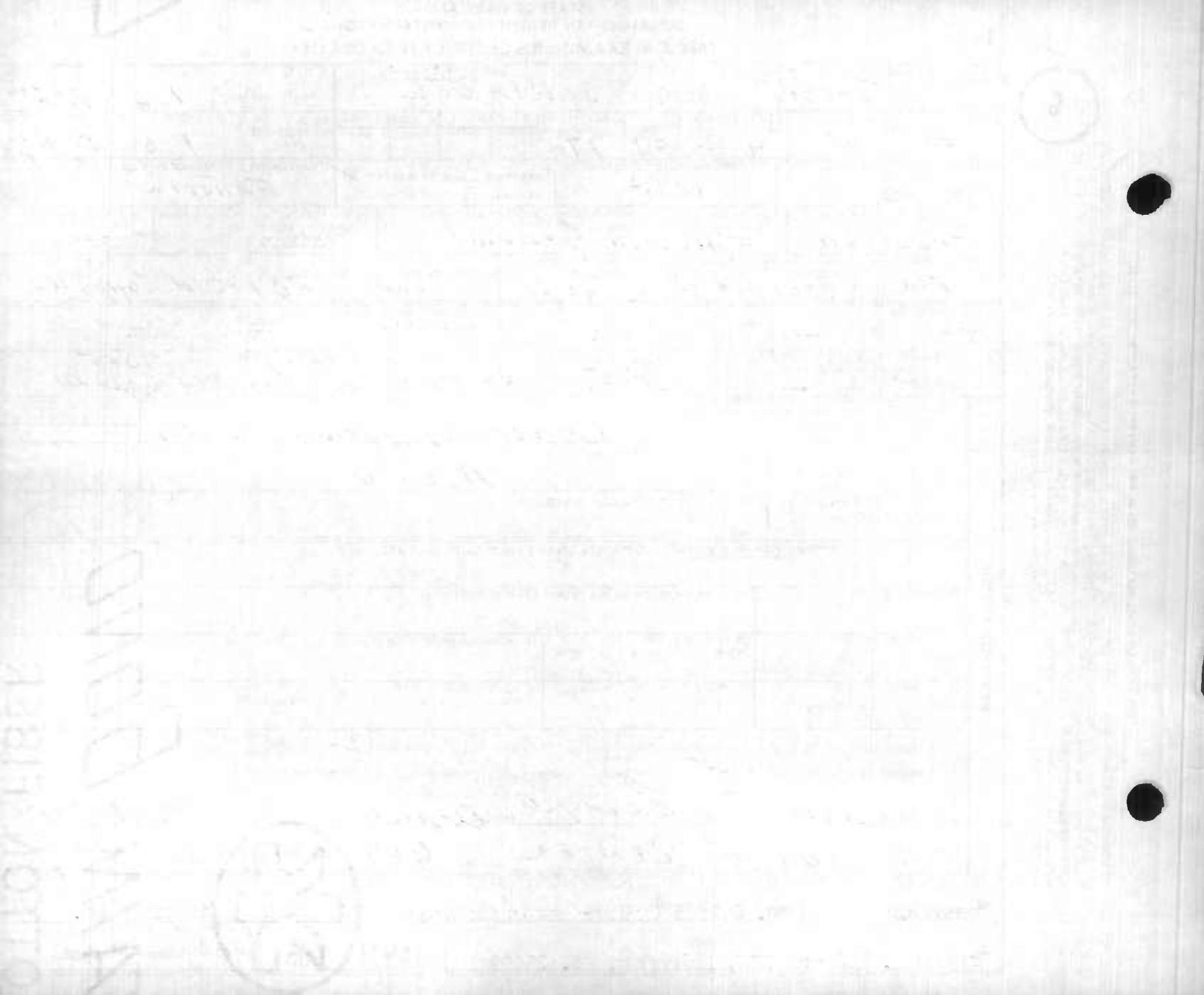
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												02085
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
ERNEST			LEON	SADLER		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	16	1985	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White	March 15, 1958	26 yrs.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	16	1985	8:26 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
California		USA						Harford County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace		Harford Memorial Hosp.					Parts Manager			Farm Equip.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS				
Maryland		Harford		Havre de Grace		<input checked="" type="checkbox"/>		7 Bay Boulevard/21078				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Ernest		Lloyd	Sadler	Janice		Yvonne	Meadows					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			n/a			214-70-8660			M.J. Sadler, 7 Bay Blvd., Havre de Grace, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8122 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>XXX</b> MONTH DAY YEAR 6 P.M. 1-16- 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Operator of motorcycle/pick up truck collision						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 155 & Hopkins Rd., Havre de Grace, Harford Co., Md.						
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion						
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED 1-17-85						
23a. BURIAL, CREMATION, REMOVAL SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
Burial			Jan. 19, 1985			Baker Cemetery			County			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399						JAN 21 1985 Julie Carlson Bredell						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOU. PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 02086					
1- STATE REGISTRAR			2a. DATE KNOWN OF DEATH MATED										2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Jacob			MIDDLE Schlauch			LAST			MONTH 16	DAY 1985	YEAR 6:20 M			
2. SEX M W			3. DATE OF BIRTH MONTH 4 YEAR 2 07			4. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 16 1985 6:20 M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pitts. Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Fallston				
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gardner			12b. KIND OF BUSINESS OR INDUSTRY Farm								
13a. STATE Md			13b. COUNTY Harford			13c. CITY OR TOWN Poppe			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1001-Old Poppe Rd					
14. FATHER'S NAME FIRST John			MIDDLE			LAST Schlauch			15. MOTHER'S MAIDEN NAME FIRST Magdaline			MIDDLE LAST Heim					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 317-36-4338			16c. INFORMANT (Employer) ADDRESS 21085			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
16e. IF YES, GIVE WAR OR OATES			217-36-43354 Mr. Rogers			16f. ADDRESS 1001 Old Poppe Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <i>ASCD</i> DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION STREET			21d. CITY OR TOWN			21e. COUNTY			21f. STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. TITLE (SPECIFY) Luis E. Renfert, M.D. Deputy MEDICAL EXAMINER			DATE SIGNED 1-7-85								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renfert			ADDRESS 464 9th Avenue St. 1st flr			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 8, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cratin-Ferris Crematory			23d. LOCATION CITY OR TOWN W/Chester		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 9 1985			25b. REGISTRAR'S SIGNATURE Julie Anderson Pendleton								
20M 4/82																	

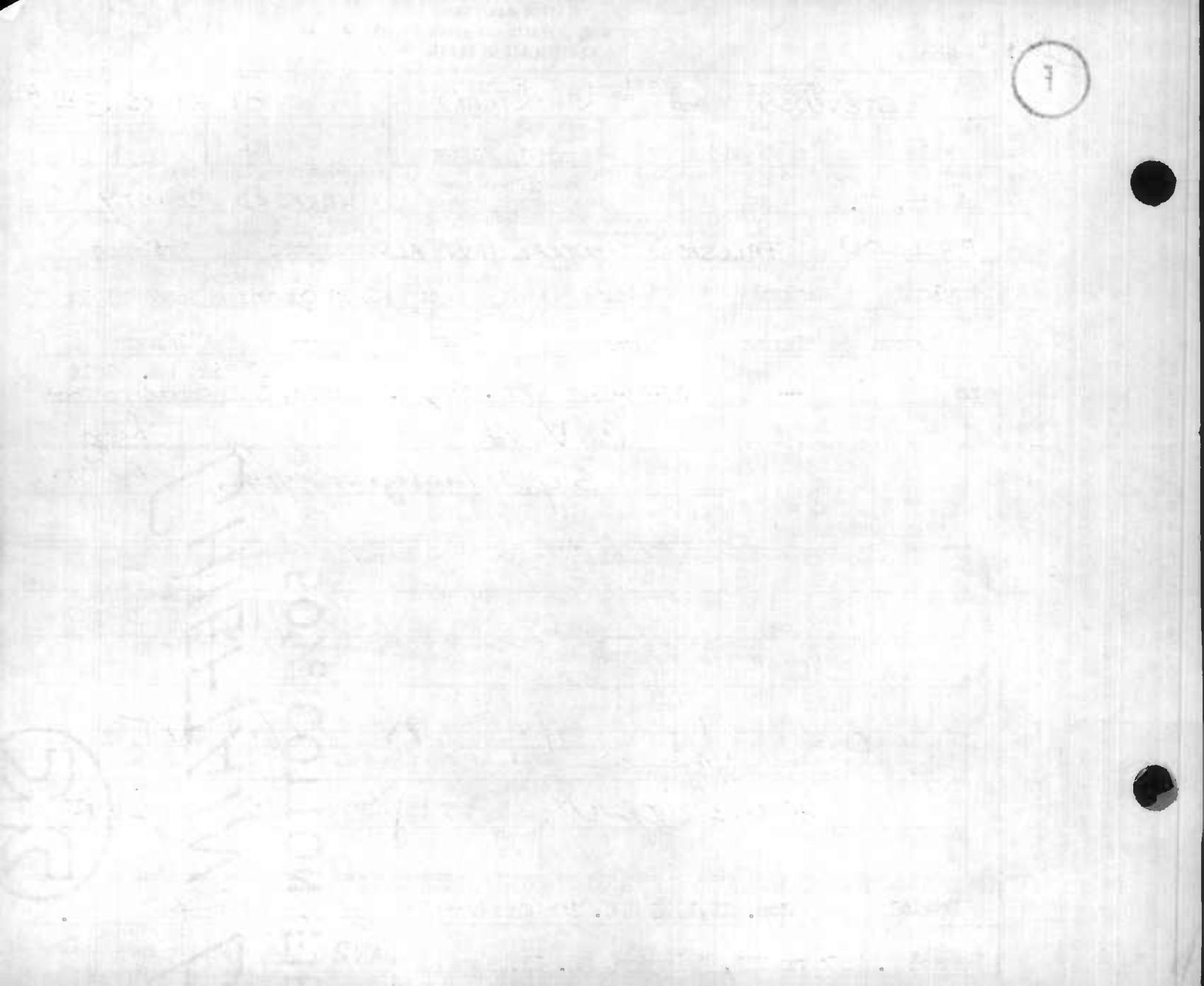


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8502081					
												REG. NO.					
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			MIDDLE Stevenson			LAST Williams			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
STEVENSON									Sherman			March 18, 1905	01	24	85	340 A	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
Male			White			MONTH DAY YEAR			79 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
Bel Air, Md.			USA						HARFORD COUNTY			FALLSTON			FALLSTON GENERAL HOSPITAL		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Maryland			Harford			Bel Air			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2630 Conowingo Road 21014			Contractor		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
George			Thomas Sherman			Joanna			no			215-10-2941			Mrs. Alma E. Sherman, 2630 Conowingo Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. V. A.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Systemic legions syndrome.</i>												<i>months</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/11/85</i> to <i>1/11/85</i> , that (I) (we) last saw the deceased alive on <i>1/23/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.																	
22b. SIGNATURE <i>Dean L. James</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>1/24/84</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Jan. 26, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery			23d. LOCATION CITY OR TOWN Bel Air			COUNTY Harford			STATE Md.		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR ADDRESS			25b. REGISTRAR'S SIGNATURE <i>JAN 25 1985 Julie Davidson Pendleton</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

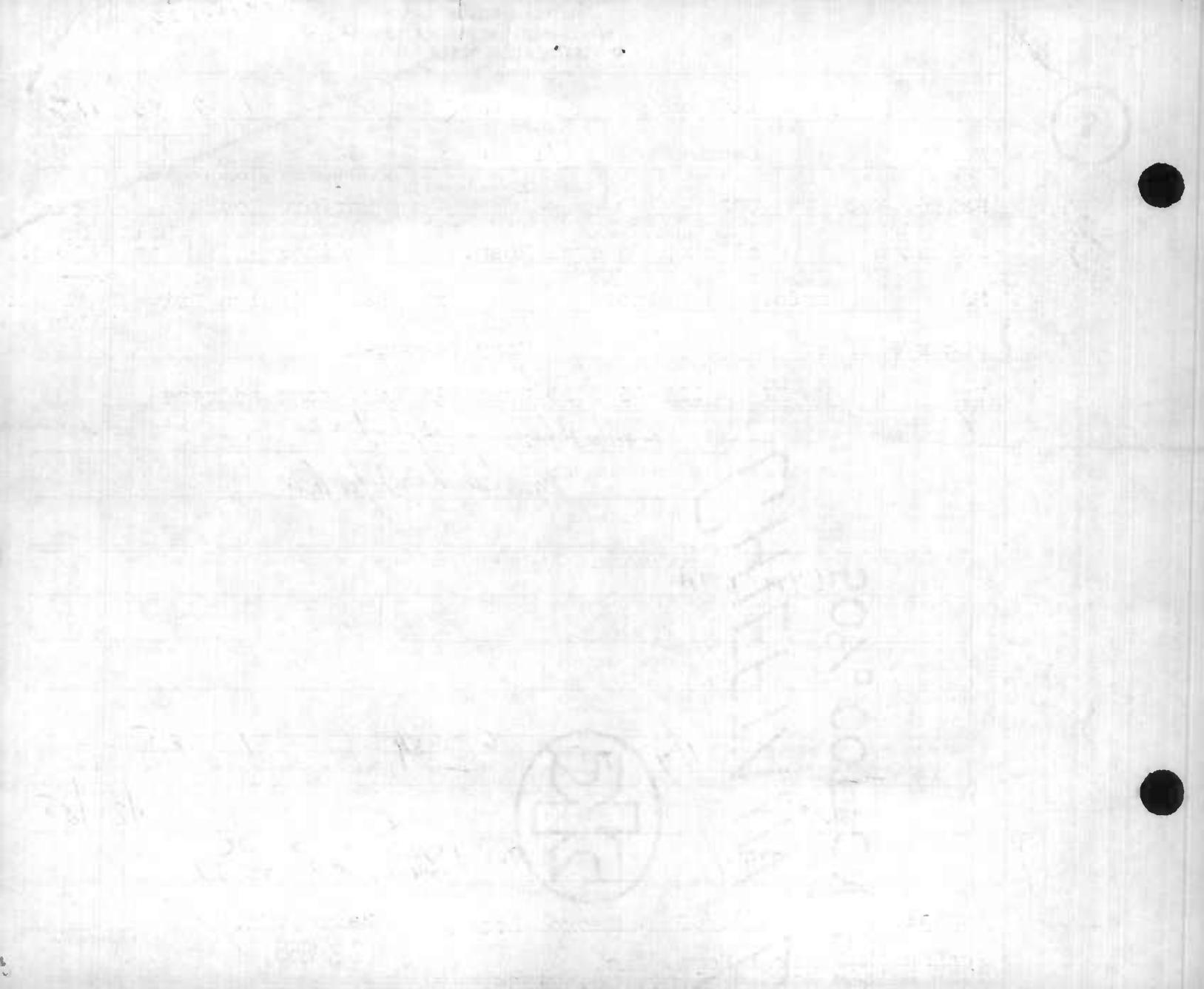
retd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Item 13), it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event,

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 5 0 2 0 8 8			
						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Louis J. Slifker Sr.			1/20/85			1985	11:40 AM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
Male		Cauc.	MONTH	DAY	YEAR	54	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto., Md.		USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hosp.			Auditor			Baltimore Gas & Elec.	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9820 Richlyn Drive, Hall, Md.	
14. FATHER'S NAME FIRST		MIDDLE		EAST		15. MOTHER'S MAIDEN NAME FIRST		21128	
Peter Slifker						Mary Pazourek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE)		17. INFORMANT		ADDRESS			
Yes		WW II		212-05-2813		Edna Slifker, same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Pulmonary Arrest</i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>LYMPHEMA</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>17 85</i> to <i>6 19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>M. Y. O. THAN</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/21/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>901 FRANKLIN ST. DR BALTO., MD 21237</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1/24/85		23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart		23d. LOCATION CITY OR TOWN Balto., Md.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236						25a. DATE REC'D. BY REGISTRAR JAN 23 1985		25b. REGISTRAR'S SIGNATURE <i>J. Schimunek</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the funeral director's permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 11 shows any injury, or other traumatic event, the medical examiner may be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8502089		
						REG. NO.		
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			1. FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
	JESSIE JAMES SLIVER					January 5, 1985	1:56 P M	
3. SEX	3. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male	White		April 25, 1918		66			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Fawn Grove, Pa.	USA				Harford Co.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Aberdeen	621 Carsins Run Road					Truck Driver		State Govt.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE Maryland		
						13b. COUNTY Harford		
						13c. CITY OR TOWN Aberdeen		
						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 621 Carsins Run Road 21001	
						14. FATHER'S NAME FIRST MIDDLE LAST Stanley Matthew Sliver		
						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Elizabeth Coombs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
no		166-12-4496		Betty A. Billings, 621 Carsins Run Road		Aberdeen, Md. 21001		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.						Respiratory Arrest w/ metastatic Carcinoma of Lung		
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22e. I certify that (I) (this hospital) attended the deceased from 9-25-1984, to 1-5-1985, that (I) (we) last saw the deceased alive on 12-11-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (I) (We) did not view the body after death.								
22f. SIGNATURE Murli N. Mathur		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED Jan. 7, 1985		
22h. PHYSICIAN'S NAME (TYPE OR PRINT) Murli N. Mathur, M.D.		22i. ADDRESS 1305 Fallston Road, Fallston, Md. 21047						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 8, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air		23d. LOCATION CITY OR TOWN Harford		COUNTY STATE Md.
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009					25a. DATE REC'D. BY REGISTRAR JAN 9 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson Pendall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502090						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
Margaret N.			Smith			1/3/85			1/2 AM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Female		White		5 4 1916			68			YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Sunbury, Pa.		U. S. A.					Harford									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH ACTIVITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Fallston		Fallston Gen Hosp.					Housewife			Home keeping						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Md.		Harford		Belair						401 Moores Mill Rd. 21014						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME												
Harry C. Hoover				Ruth												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS									
no		188-38-0451					Miss Mary Smith, Apt. 1C, Balto. Md. 21236									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a hypertension, diabetes, congestive heart failure																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-2, 1985, to 1-3, 1985, that (I) (we) last saw the deceased alive on 1-3, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.																
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED									
M. S. SHARAF EL DEANE							P.O. Box 935 Edgewood 21040									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-1985		23c. NAME OF CEMETERY OR CREMATORIAL West Side Cemetery			23d. LOCATION CITY OR TOWN Shomoken Dam Snyder Co. Pa.									
24. FUNERAL DIRECTOR NAME Lassah (F. H. 1750 Belair Rd. Kingsville, Md. 21087)				25a. DATE REC'D. BY REGISTRAR JAN 7 1985												

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use on the burial permit #6-11. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 10, show cause of injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8502091

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Madeline MADELINE	MIDDLE	LAST Elizabeth Spillman SPILLMAN	2a. DATE OF DEATH MONTH DAY YEAR 01 14 85	2b. HOUR 12 <sup>00</sup> Noon		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1912	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hos.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 956-D Hillswood Road 21014			
14. FATHER'S NAME FIRST Joseph		MIDDLE Raymond	LAST Feder	15. MOTHER'S MAIDEN NAME FIRST Albertina	MIDDLE (nm)	LAST Moyer	ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Cathy Shimek, 654 Frans Dr., Abingdon, Md. 21009	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY FAILURE</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG ABSCESS</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SCLERODERMA</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)				
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>85</u> , to <u>11/4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.								
22b. SIGNATURE <u>Andrew Nowakowski MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/14/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Andrew Nowakowski MD</u>		22e. ADDRESS <u>125 N. MAIN ST. BEL AIR, MD 21014</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 15, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Cratin-Ferris Crematory		23d. LOCATION CITY OR TOWN W. Chester	COUNTY	STATE Pa.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JAN 16 1985		25b. REGISTRAR'S SIGNATURE <u>Laurel Rendell</u>				

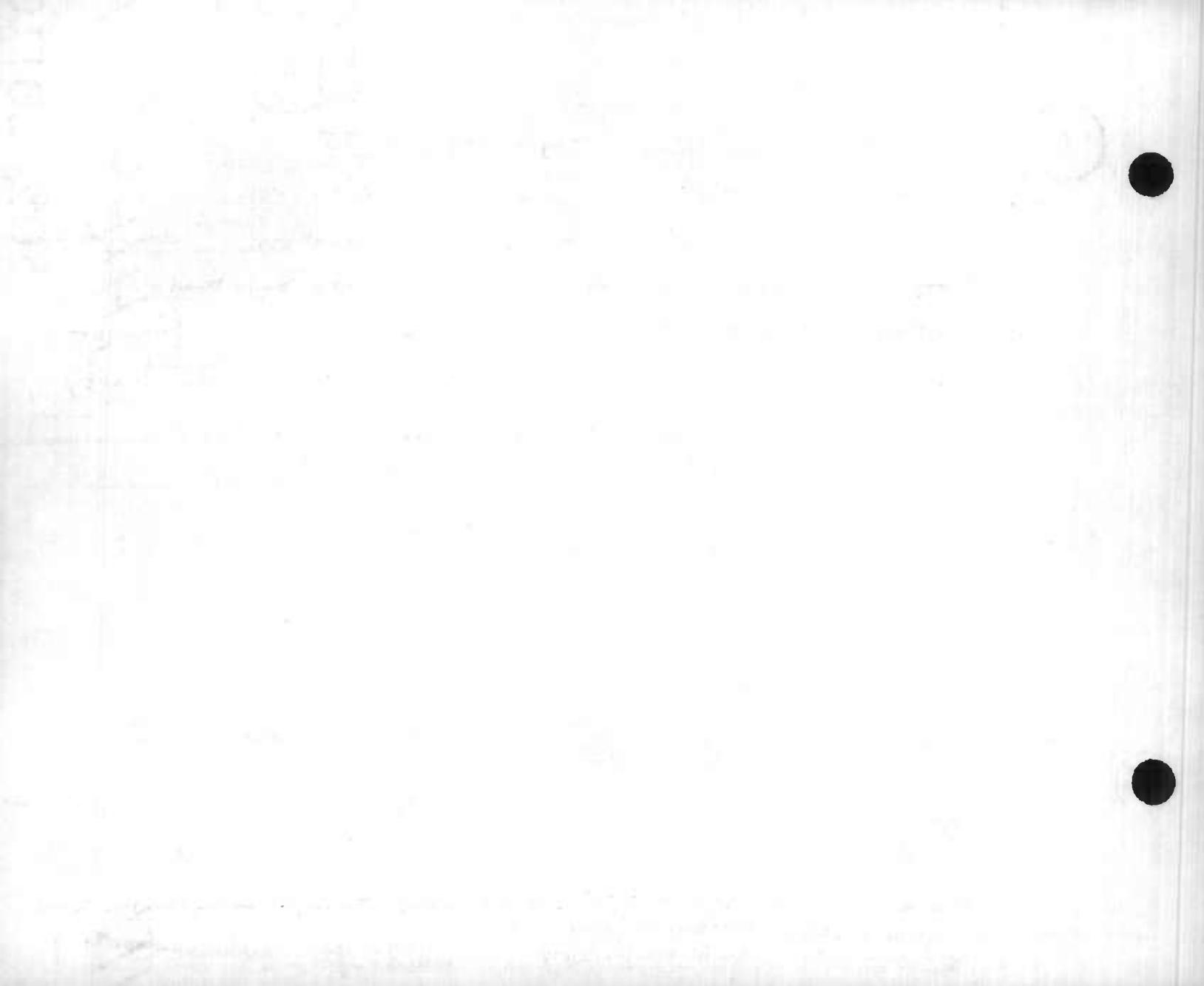


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Page 1) and 2 should be detached for use as the burial transit permit. Then please remove carbon copies (Pages 1 and 2) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8502092			
REG. NO.															
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			January 23, 1985	4 AM		
Effie Viola Stamper															
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			75		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			May 2, 1909			75			YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Harford			
TENN.			U.S.A.												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Harford de Grace			Harford Mem. Hospital									SEAMSTRESS			
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Maryland			Harford Co.			Street (21154)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1039 Doyle Road 21154			
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			
Wiley			Monroe			Baldwin			Rosetta			WEAVER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT(SO) 452-5834 ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO			28-28-5704			Maj Jerry D. STAMPER 3549 Ady Road			STREET, Maryland 21154						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic (Liver) Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>due to Fatty infiltration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>of Liver</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-31, 1985, to 1-23, 1985, that (I) (we) last saw the deceased alive on 1-23, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1/23/85			
22b. SIGNATURE Dante Monakil			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL			22e. ADDRESS Harford de Grace, Md 21076												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 25, 1985			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014						
24. FUNERAL DIRECTOR Joseph William Foster			50 W. Broadway & Luthans St ADDRESS Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR JAN 25 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendleton						

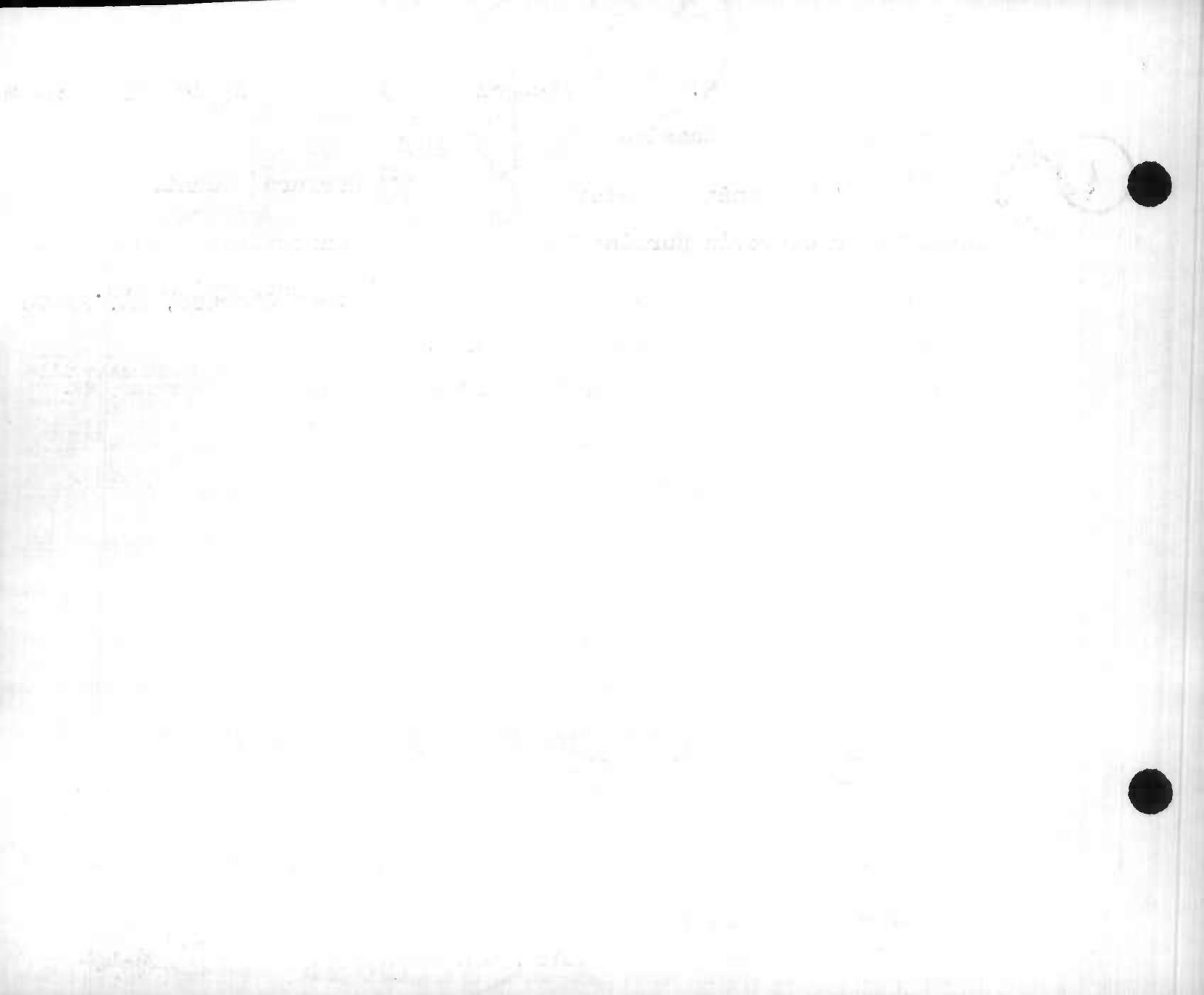


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death, or within 24 hours of the physician's return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	5	0	2	0	9	3
										REG. NO.						
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Susan		MIDDLE R.		LAST Stengel		2a. DATE OF DEATH MONTH JAN.		DAY 14	YEAR 85	2b. HOUR 6	30pm	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 2		DAY 9		YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED X		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		MD.		
10. CITY OR TOWN OF DEATH Havre De Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) Brevin Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper										12b. KIND OF BUSINESS OR INDUSTRY Private Home		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 421 South Union Ave. Havre De Grace, MD. 21078								
14. FATHER'S NAME FIRST George		MIDDLE		LAST Stengel		15. MOTHER'S MAIDEN NAME FIRST Roseanna										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-38-5763		17. INFORMANT Ms. Virginia Rothwell		ADDRESS 502 Michaelsville Perryman, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		
														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
														1/day		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost																
(b) Pneumonia																
{ DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)												
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 83</u> to <u>Jan. 14 19 85</u> , that (I) (we) last saw the deceased alive on <u>Jan. 14 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Howlett Jackson		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1-14-85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howlett Jackson		22e. ADDRESS 1315. UNION Ave. Havre De Grace MD 21078														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/14/85		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 20 1985		25b. REGISTRAR'S SIGNATURE Julia Jackson Rothwell										

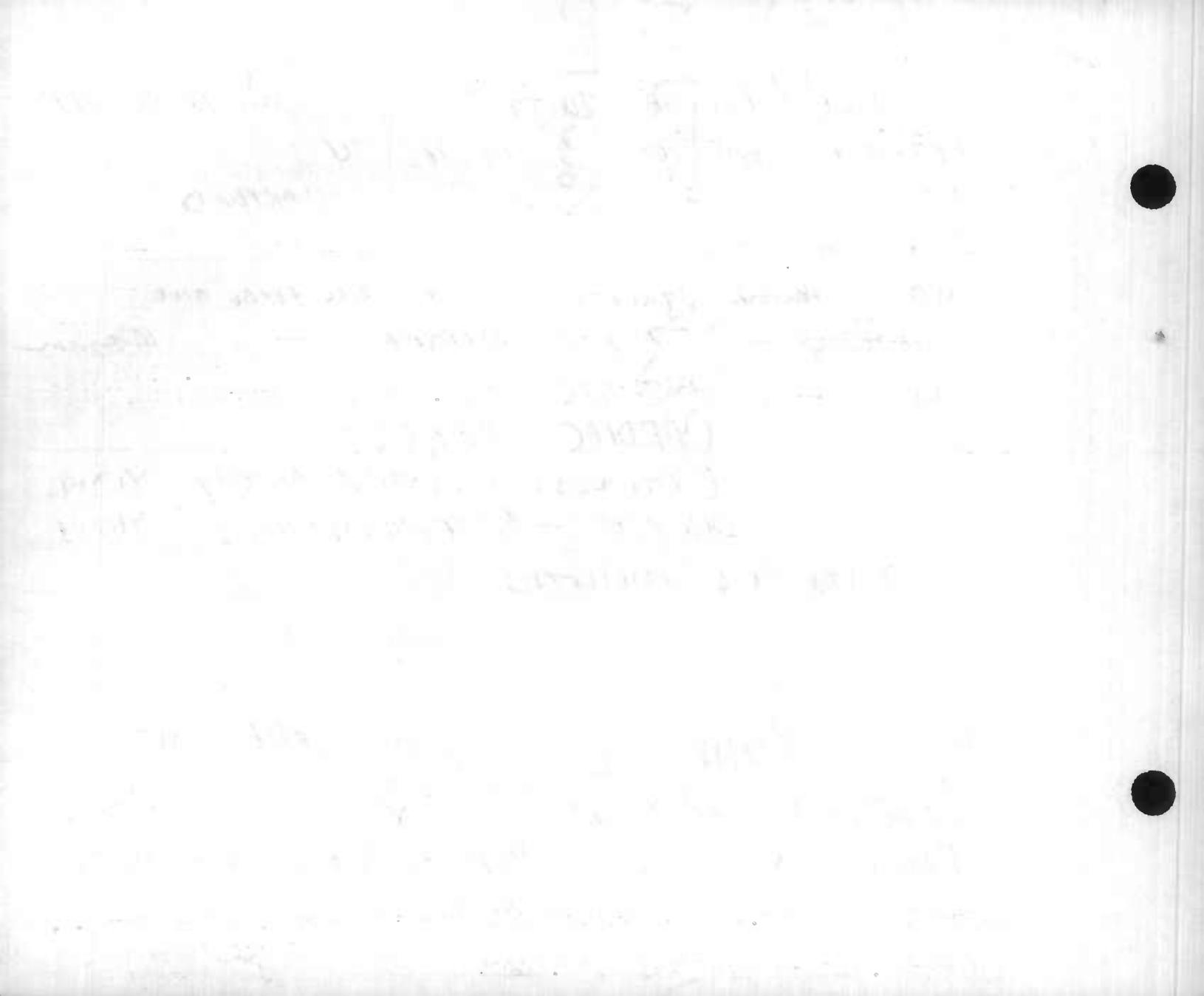


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502094		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)				FIRST Nannie MIDDLE Elvina LAST Suitt			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3. SEX Female				4. RACE White			5. DATE OF BIRTH MONTH 3 DAY 13 YEAR 10			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
7a. BIRTHPLACE COUNTRY NC				7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH STREET, MD				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3164 Forge Hill Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. STATE MD				13b. COUNTY Harford			13c. CITY OR TOWN STREET			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME John				15. MOTHER'S MIDDLE NAME MARTHA			13e. STREET ADDRESS / ZIP CODE 3164 FORGE HILL Road 21154			14. MIDDLE NAME Hamm		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 231327665			17. INFORMANT Martha L. Warden, 2802 Preston Lane, Abingdon			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH --		
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) EXTENSIVE CORONARY ARTERY DISEASE - ARTERIOSCLEROSIS YEARS YEARS												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: DIABETES MELLITUS												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/8 1985 to 11/8 1985, that (I) (we) last saw the deceased alive on 11/8 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. NATURE SICIAN'S NAME (TYPE OR PRINT)		22c. DEGREE			22d. DATE SIGNED 11/9/85							
DANTE N. MONAKIL												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 22, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cemetery			23d. LOCATION CITY OR TOWN Chestnut Hill Methodist Chestnut Hill Ashe- N.C.				
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 21 1985 John Wilson Pendell										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502095				
										REG. NO.				
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST EDNA	MIDDLE S.	LAST Sullins			2a. DATE OF DEATH Jan 24 1985	MONTH JAN	DAY 24	YEAR 1985	2b. HOUR 8:15 P.M.
3. SEX Female		4. RACE white			5. DATE OF BIRTH MONTH Apr.			DAY 19		YEAR 1931		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford						
10. CITY OR TOWN OF DEATH Laure de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home						
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 428 Susquehanna Ave Perryville, Md. 21002						
14. FATHER'S NAME FIRST John R.		MIDDLE Strimel	LAST	15. MOTHER'S MAIDEN NAME Harriet			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 216-28-8581			17. INFORMANT Garnet Sullins									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-23-85 to 1-24-85, that (I) (we) last saw the deceased alive on 1-24-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 1-24-85				
22b. SIGNATURE M.S. Sharafeddine		22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.S. Sharafeddine			DEGREE ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-25-85			23c. NAME OF CEMETERY OR CREMATORIAL Cetain & Ferris			23d. LOCATION CITY OR TOWN West Chester		COUNTY	STATE Chester Pa.			
24. FUNERAL DIRECTOR Funeral Home		ADDRESS North East, Md.			25a. DATE REC'D. BY REGISTRAR JAN 28 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						



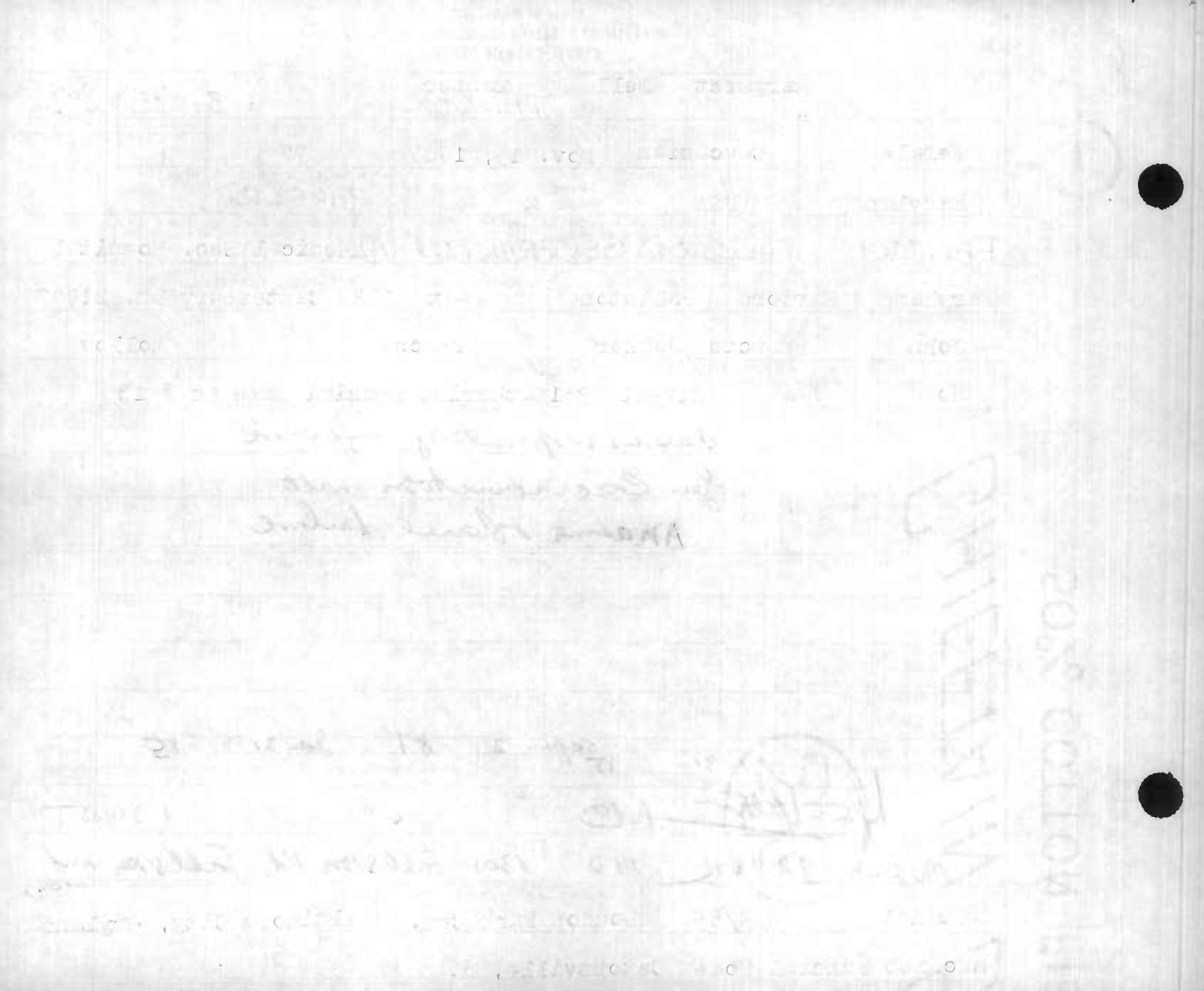
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 2 0 9 6			
										REG. NO.			
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST Margaret	MIDDLE Dell	LAST Tanner	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
DELL		DELL		TANNER		1 31 85		8 25		P.M.			
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		MONTH Nov. 15, 1907		YEAR		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland		USA		HARFORD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
FALLSTON		FALLSTON GENERAL HOSPITAL		Medical Sec.		Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Harford		Fallston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3229 Canterbury Ln. 21047					
14. FATHER'S NAME		FIRST John	MIDDLE Francis	LAST Walker	15. MOTHER'S MAIDEN NAME		FIRST Frances	MIDDLE	LAST Molloy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		N/A		Katherine Brusini		Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory failure</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>gen carcinomatosis with</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Apnea or heart failure</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET									
				CITY OR TOWN									
				COUNTY									
				STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 2</i> , 1981, to <i>Jan 31 85</i> , 1985, that (I) (we) lost saw the deceased alive on <i>1-31-</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.													
22b. SIGNATURE <i>Murphy Walker, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-31-85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MURPHY, MURPHY, M.D.</i>		22e. ADDRESS <i>1305 Fallston Rd, Fallston, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 2/4/85		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.		23d. LOCATION CITY OR TOWN Baltimore City, Maryland							
						COUNTY							
						STATE							
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md.		25a. DATE RECD. BY REGISTRAR FEB 1 1985		25b. REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate returned to the medical examiner.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

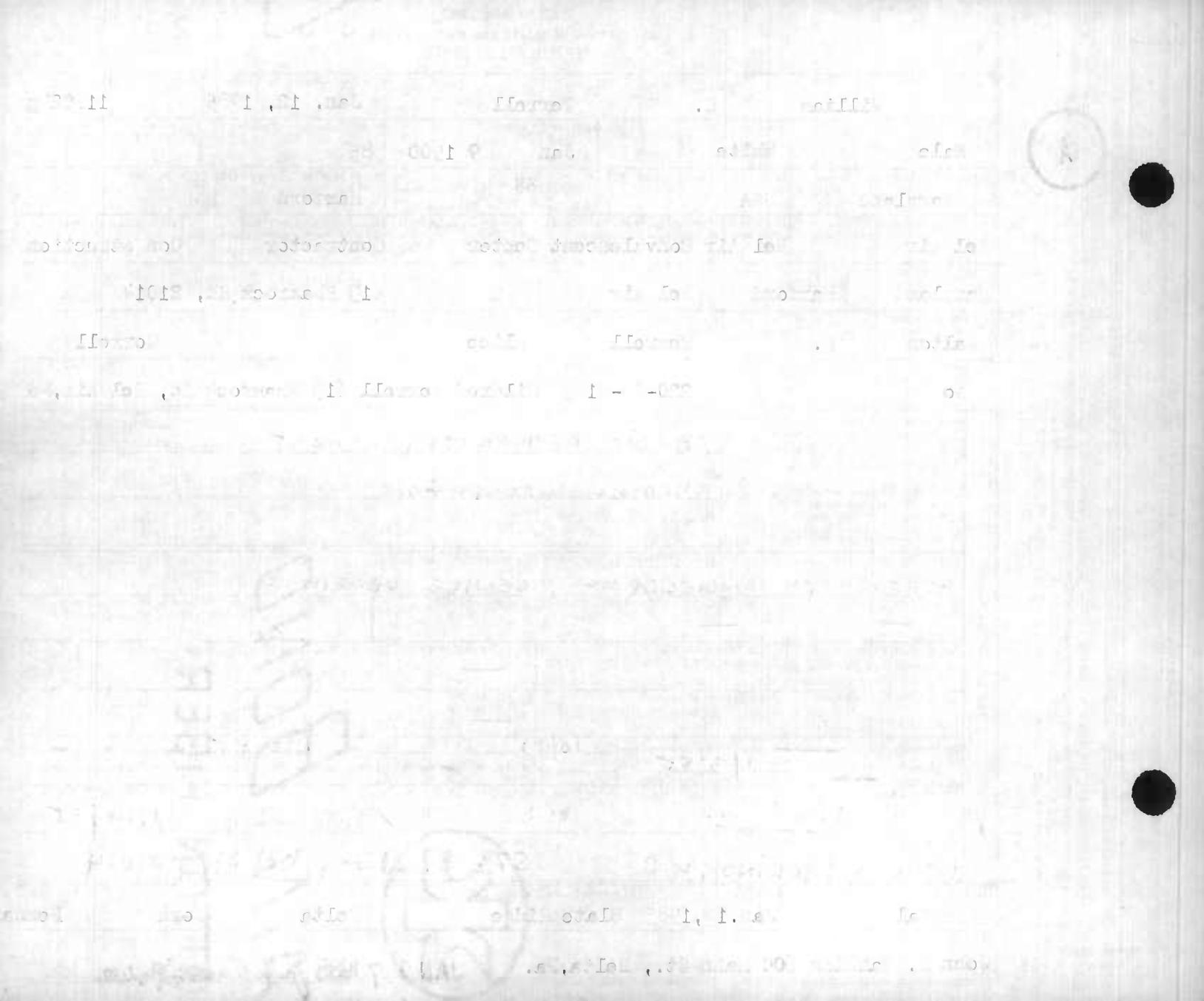
8 5 0 2 0 9 7

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
William C. Terrell						Jan. 12, 1985				11:02 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH	DAY	YEAR	85	MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		USA						Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bel Air			Bel Air Convalescent Center			Contractor			Construction		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE		
Maryland			Harford		Bel Air				613 Shamrock Rd, 21014		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
Walton			M.		Terrell	Alice			Gorrell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			220-03-6163			Mildred Terrell			613 Shamrock Rd, Bel Air, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CARDIO-RESPIRATORY ARREST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) CHRONIC UROSEPSIS								
			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
HEREDITARY			ANGIO-DEMA, SENILE DEMENTIA								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (This hospital) attended the deceased from 10/81, 19____, to 1/12/85, 19____, that (I) ( ) lost saw the deceased alive on 1/3/85, 19____, and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above, (I) ( ) (did not) view the body after death.											
22b. SIGNATURE David Padriño			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/14/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 57 E. Broadway, Bel Air, 21014								
DAVID R. PADRINO, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Jan. 16, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge			23d. LOCATION CITY OR TOWN Delta		
Burial									COUNTY York	STATE Penn.	
24. FUNERAL DIRECTOR NAME John H. Harkins			ADDRESS 600 Main St., Delta, Pa.			25a. DATE REC'D. BY REGISTRAR JAN 17 1985			25b. REGISTRAR'S SIGNATURE Julia David Padriño		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate returned to the medical examiner.



10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

signed by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be directed to the State Director of Health and Mental Hygiene prior to burial, cremation or removal. It will then be filed with the State Director of Health and Mental Hygiene. If any item on this certificate is marked with an asterisk (\*), it is important that it be checked and signed by the attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8502098	
						REG. NO.	
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
			GLADYS ALBERTA THOMAS			01 05 85	3:11 AM
3. SEX <i>F</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>03 26 18</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>66</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>	
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <i>Delta, Pa.</i>		14. COUNTY <i>York</i>		13c. CITY OR TOWN <i>Delta</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>Ex</i>	
15. FATHER'S NAME FIRST <i>Joseph</i>		MIDDLE <i>F.</i>		LAST <i>Bay</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Margaret</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-24-3978</i>		17. INFORMANT <i>Ivan Hall</i>		12b. STREET ADDRESS / ZIP CODE <i>RD 1, 17314</i>	
						12c. ADDRESS <i>RD 1, Delta, Pa., 17314</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>asystole</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiac arrest</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Severe Asthma</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>1-5</i> , 19 <i>84</i> , to <i>1-5</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. DATE SIGNED					
<i>W. Stratford May, M.D.</i>		<i>1-5-84</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan 8, 1985</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>St. James</i>		23d. LOCATION CITY OR TOWN <i>Jarrettsville</i>	
24. FUNERAL DIRECTOR <i>John M. Harkins</i>		ADDRESS <i>P O Box 485, 600 Main St, Delta Pa.</i>		25. DATE RECEIVED BY REGISTRAR AND REGISTRAR'S SIGNATURE <i>JAN 1 1985 John Harkins</i>		STATE <i>Md</i>	



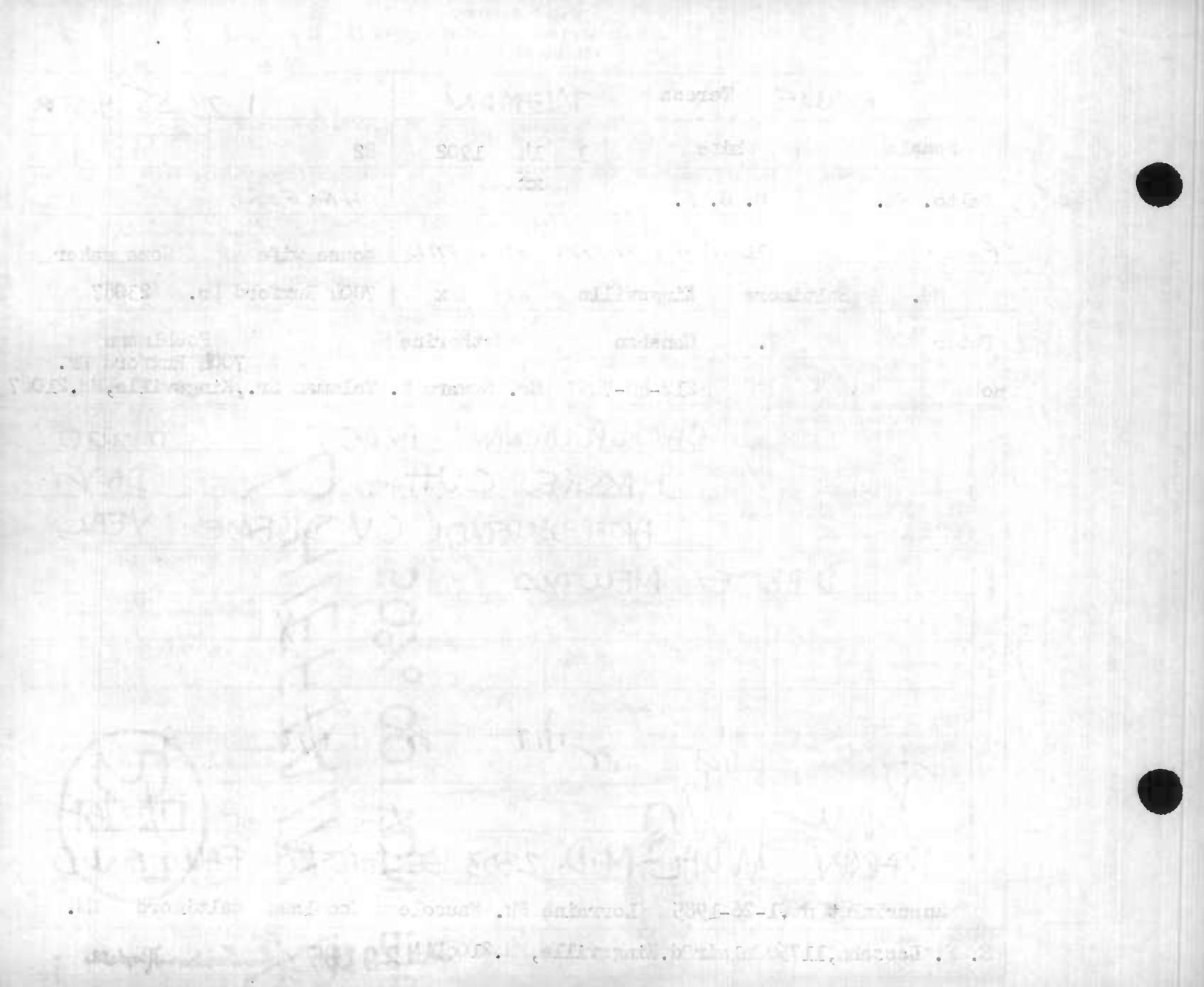
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8	5	0	2	0	9	9		
				REG. NO.								
1 - FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)		FIRST NELIE	MIDDLE Teresa	LAST TOLZMAN	20. DATE OF DEATH		MONTH 1	DAY 23	YEAR 85	2b. HOUR 4:55P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3		DAY 14	YEAR 1902	6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS YRS.		
7. BIRTHPLACE (COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION House wife		12b. KIND OF BUSINESS OR INDUSTRY Home maker						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7004 Ruxford Dr. 21087				
14. FATHER'S NAME FIRST Peter		MIDDLE F.		LAST Lanahan		15. MOTHER'S MAIDEN NAME FIRST Katherine		MIDDLE Poehlmann		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-40-7457		17. INFORMANT Mr. Edward F. Tolzman Sr., Kingsville, Md. 21087		ADDRESS 7004 Ruxford Dr.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.		18c. DUE TO, OR AS A CONSEQUENCE OF (b)		18d. DUE TO, OR AS A CONSEQUENCE OF (c)		18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAY				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/23 08 1985 to 1/23 08 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. (I) (we) did not view the body after death.		22b. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/23/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY		22e. ADDRESS NOTT M.D. 2303 BELAIR RD. FALLSTON MD										
23a. BURIAL, CREMATION REMOVAL (SPECIFY) Entombment		23b. DATE 1-26-1985		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Pk. Mausoleum		23d. LOCATION Woodlawn		23e. CITY OR TOWN Baltimore		Md.		
24. FUNERAL DIRECTOR E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21088				25a. DATE REC'D. BY REGISTRAR JAN 29 1985		25b. REGISTRAR'S SIGNATURE Julie Lassahn-Pardelle						



10  
PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON IN STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												02100	
												REG. NO.	
1- STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 1 12 85 3PM			2b. HOUR 301 M	
DAVID Carlton TRIVETTE													
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 11/12 1985 3PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD		10. CITY OR TOWN OF DEATH FALSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2000 Kingsforth Dr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN FALSTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2000 Kingsforth Dr. 21047		12b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME FIRST VEN MIDDLE V. LAST TRIVETT			15. MOTHER'S MAIDEN NAME MOLLIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-34-1843			17. INFORMANT ANN TRIVETTE (WIFE) SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>accident. (Falling tree).</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Luis E. Renjel M.D.</u> TITLE (SPECIFY) EXAMINER'S NAME <u>Luis E. Renjel</u> ADDRESS <u>404 Alluvia St. HARFORD</u>												DATE SIGNED <u>11/12/85</u>	
23a. BURIAL, CREMATION, REMOVAL ISPECIFIED			23b. DATE 1-16-85			23c. NAME OF CEMETERY, OR CREMATORIAL HIGHVIEW CEMT			23d. LOCATION CITY OR TOWN FALSTON			25a. DATE REC'D. BY REGISTRAR JAN 14 1985	
24. FUNERAL DIRECTOR NAME <u>SCHIMMEL F.H.</u> ADDRESS <u>9705 BELAIR Rd. 21236</u>												25b. REGISTRATION NUMBER	

Roger B. Smith

A

2011/11/11

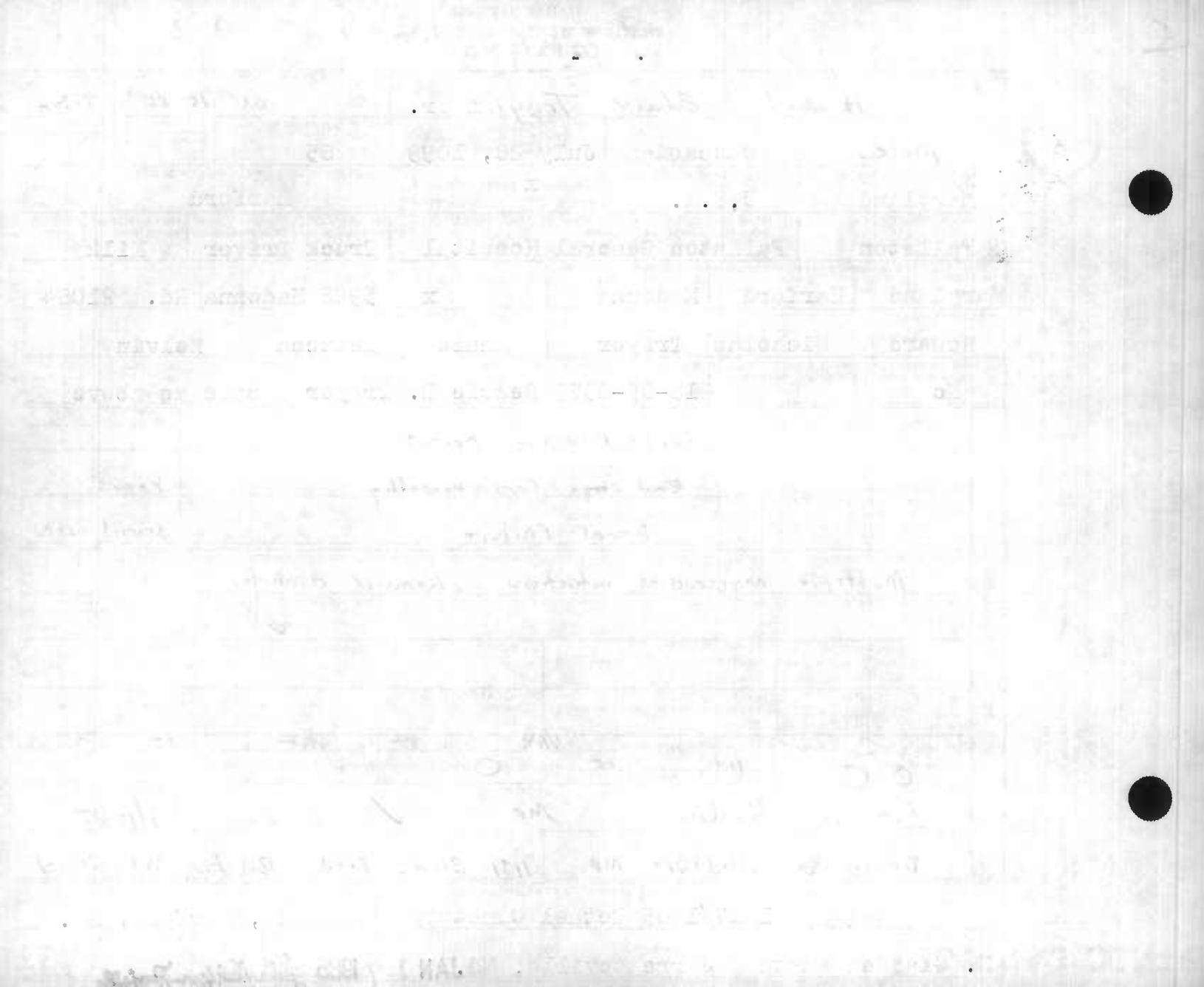
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 min be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked, or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8502101	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Howard Edwin Troyer Sr.			01	15	85		7:30 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH July 28, 1899	6. AGE [IN YEARS LAST BIRTHDAY] 85	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Milk		
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Madonna	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3928 Madonna Rd. 21084			
14. FATHER'S NAME Howard	MIDDLE Nicholas	LAST Troyer	15. MOTHER'S MAIDEN NAME Annie	MIDDLE Rebecca	LAST Melvin	ADDRESS same as above	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO 213-05-8373	17. INFORMANT Bessie L. Troyer	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End stage Cardiomyopathy</u> <span style="float: right;">Years</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u> <span style="float: right;">several weeks</span>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Multiple myocardial infarctions. chemical diabetes</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>11/0</u> , 19 <u>85</u> , to <u>11/5</u> , 19 <u>85</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>11/4</u> , 19 <u>85</u> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we did) (did not) view the body after death.							
22b. SIGNATURE <u>David W. McClure</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/15/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID W. MCCLURE MD</u>	22e. ADDRESS <u>1131 Bel Air Road, Bel Air, Md. 21014</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/17/1985	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	23d. LOCATION CITY OR TOWN Madonna, Harford, Md.	23e. COUNTY	23f. STATE		
24. FUNERAL DIRECTOR NAME <u>M. Gladden Kurtz</u>	ADDRESS <u>Jarrettsville, Md.</u>	25e. DATE REC'D. BY REGISTRAR JAN 17 1985	25f. REGISTRAR'S SIGNATURE <u>J. Gladden Kurtz</u>				

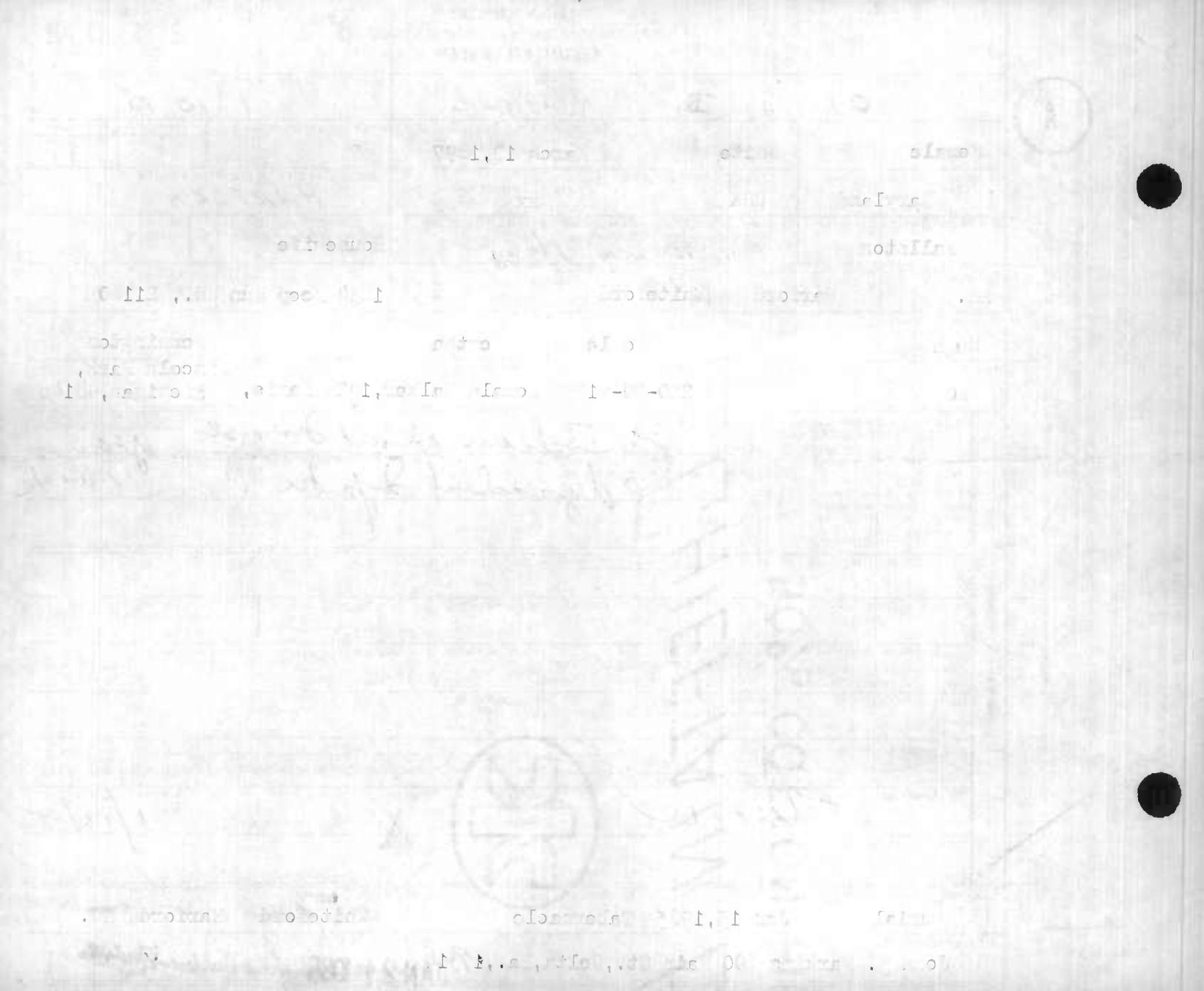


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502102		
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Oleita B. Walker						1/10/85			M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		March 13, 1897			87					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY		
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford		Maryland			Fallston Gen Hosg			Housewife MD.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ZIP CODE		
Md.		Harford		Whiteford						1834 Deep Run Rd., 21160		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Hugh				Bertha			NO			220-20-7179		
16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		17. INFORMANT ADDRESS										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.		Donald Walker, 1924 Paris, Michigan, 48146										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 1 week										
DUE TO, OR AS A CONSEQUENCE OF (b)		20. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE			22c. DEGREE									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Jan 15, 1985			Tabernacle			Whiteford Harford Md.			
24. FUNERAL DIRECTOR John H. Harkins 600 Main St., Delta, Pa., 17344												
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 21 1985 Julian L. Wilson, Jr.												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal office must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8502103								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	26 HOUR		
GRACE Hess WALTERS												1-25-85						2 30		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			IF UNDER 24 HRS					
Female			Caucasian			Month Day Year Jan. 8, 1906			79 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.												HARFORD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
FAIRFORD			FALLSTON GENERAL HOSPITAL												Teacher			Education		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE								
Maryland			Harford			Fallston			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2905 Nelson Lane 21047								
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Harry			Frederick Hess			Sarah			212-38-2331			R. Glenn Walters			same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Edentate Pneumonia</i>																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Acute Leukemia</i>																				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Leukemia</i>																				
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>Sep. 1984</i> to <i>Jan. 1985</i> , that (I) (we) last saw the deceased alive on <i>1/25/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																				
22b. SIGNATURE: <i>Myo Thant</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Myo Thant</i>			22e. ADDRESS <i>9101 FRANKLIN ST. DR 3rd, MD 21237</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1/28/1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Bel Air</i>			COUNTY <i>Harford</i>			STATE <i>Md.</i>					
24. FUNERAL DIRECTOR NAME <i>M. Gladden Kurtz</i>			ADDRESS <i>Jarrettsville, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 3 0 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson, Registrar</i>											



X

POE COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502104						
										REG. NO.						
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		January 20, 1985			11:15 AM				
ANNA MABLE WELCH																
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female			White		Mar. 5, 1895			89			YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Wise, Virginia			USA					Harford County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (ENTER INSURANCE FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Churchville			3607 Aldino Road		Housewife											
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Harford		Darlington			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3332 Hughes Road			21034		
14. FATHER'S NAME FIRST			MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Jermiah			--		Eva			Jean			Daugherty					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no			233-40-6047		Mrs. Nellie Welch, 3332 Hughes Road, Darlington			Md. 21034								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CARDIAC ARREST						
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC																
DUE TO, OR AS A CONSEQUENCE OF (c) HEART DISEASE																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Recurrent STROKE																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
19b.																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 1/10, 1985, to 1/20, 1985, that (I) (we) last saw the deceased alive on 1/20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Dante N. Monakil										DEGREE		22c. DATE SIGNED 1/20/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKIL										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Jan. 23, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN Bel Air Harford Md.		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009										25a. DATE REC'D. BY REGISTRAR JAN 22 1985		25b. REGISTRAR'S SIGNATURE Davidson Randall				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8502105			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Anna			Ruth	Welsh		1 6			85	240	AM		
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White	December 9, 1890		94			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA					Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace			Harford Memorial Hospital			Homemaker							
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Harford	Aberdeen					97 Mount Royal Ave., 21001				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
David				McGovern	Elizabeth				McGovern				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			216-18-3196			E.W. Welsh, 3737 Harmony Church Rd., H.de G., MD			21078				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >5 yes			
due to, or as a consequence of (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/29, 1984, to 11/6, 1985, that (I) (we) lost saw the deceased alive on 11/5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE B.J. Plunkett, M.D.										DEGREE	22c. DATE SIGNED 1-6-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Removal/Cremation			Jan. 7, 1985		Cratin and Ferris			West Chester, Chester, Penna.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399						JAN 8 1985			G. L. Tanning				



6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8502106  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>JOHN</i>	MIDDLE 	LAST <i>Wilson</i>	2a. DATE OF DEATH MONTH <i>01</i>	MONTH <i>02</i>	DAY <i>28</i>	YEAR <i>85</i>	2b. HOUR 11:50 PM		
3. SEX <i>M</i>			4. RACE <i>B</i>	5. DATE OF BIRTH MONTH <i>01</i>			DAY <i>20</i>	YEAR <i>19</i>	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS 	IF UNDER 24 HRS. HOURS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.			
10. CITY OR TOWN OF DEATH <i>Harford Co.</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FAIRSTON Sen Hosp</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Harford mill</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Harford mill</i>			
13a. STATE <i>Md.</i>			13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Darlington</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ZIP CODE <i>4211 Conowingo Rd 21034</i>		
14. FATHER'S NAME FIRST <i>John</i>			MIDDLE <i>J.</i>	LAST <i>Wilson, Sr.</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Williams</i>			ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>214-0362-74</i>			17. INFORMANT <i>Agnes Wilson same as above</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer pulmonary, heart</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of Colon with metastasis</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (the hospital) attended the deceased from <i>July 19, 84</i> to <i>1/28, 1985</i> , that (1) (we) last saw the deceased alive on <i>1/28/1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) (did not) view the body after death.												
22b. SIGNATURE <i>Myo Thank</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>1/28/1985</i>			
22e. PHYSICIAN'S NAME (IF DIFFERENT) <i>MYO THANK</i>			22f. ADDRESS <i>9101 FRANKLIN ST. DRIVE BETHESDA, MD 20837</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/2/85</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Berkley Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Darlington</i>			
24. FUNERAL DIRECTOR NAME <i>Arnold W. Beard 353 Fountain St. HDG, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 05 1985</i>			25b. REGISTRATION NO. <i>1234567890</i>			SIGNATURE <i>Arnold W. Beard</i>			

